

Utah State University

DigitalCommons@USU

All Graduate Theses and Dissertations

Graduate Studies

5-1998

Solution-Focused Couples' Group Therapy

LaFray Kelley

Utah State University

Follow this and additional works at: <https://digitalcommons.usu.edu/etd>



Part of the [Family, Life Course, and Society Commons](#)

Recommended Citation

Kelley, LaFray, "Solution-Focused Couples' Group Therapy" (1998). *All Graduate Theses and Dissertations*. 2573.

<https://digitalcommons.usu.edu/etd/2573>

This Thesis is brought to you for free and open access by the Graduate Studies at DigitalCommons@USU. It has been accepted for inclusion in All Graduate Theses and Dissertations by an authorized administrator of DigitalCommons@USU. For more information, please contact digitalcommons@usu.edu.



SOLUTION-FOCUSED COUPLES' GROUP THERAPY

by

LaFray Kelley

A thesis submitted in partial fulfillment
of the requirements for the degree

of

MASTER OF SCIENCE

in

Family and Human Development
(Marriage and Family Therapy)

Approved:

UTAH STATE UNIVERSITY
Logan, Utah

1998

Copyright LaFray Kelley 1998

All Rights Reserved

ABSTRACT

Solution-Focused Couples' Group Therapy

by

LaFray Kelley, Master of Science

Utah State University, 1998

Major Professor: Dr. Thorana S. Nelson
Department: Family and Human Development

Solution-focused therapy is one of the models of brief family therapy that has come into prominence during the 1980s and 90s. Whereas earlier forms of family therapy concentrated on problems and the behaviors that maintained them, solution-focused therapy places its emphasis on "exceptions" to the problem--times when it is not happening--and seeks to elaborate on and amplify these exceptions.

A solution-focused therapy model has been used with individuals, couples, and groups of individuals, but a search of the relevant literature revealed no information on its use with couples' groups. The purpose of this study was to develop a solution-focused treatment plan for a couples' group and to test its effectiveness. A single-case research design was used with a multiple baseline assessment strategy across subjects. Participants'

improvement on measures of overall marital satisfaction and specific goal achievement was considered in evaluation of effectiveness.

Five couples completed the program. Marital satisfaction was measured using the Revised Dyadic Adjustment Scale (RDAS) and the Kansas Marital Satisfaction Scale (KMS). On both measures 7 of the 10 participants showed improvement between baseline and intervention scores. Two participants showed little change in scores and 1 subject recorded a decline in score.

A self-report goal sheet utilizing a 0-10 scale was used to record progress toward individual and couple goals. Eight participants reported progress, 1 no change, and 1 a decline on both types of goals. The results of this study lend support to the supposition of positive outcomes from solution-focused couples' group work and suggest the need for further study.

(135 pages)

ACKNOWLEDGMENTS

I would like to thank Dr. Thorana Nelson for her patient guidance through the sometimes bewildering process of producing a master's thesis. Thank you for helping me make my thesis project doable and at times even enjoyable. I have learned a lot from you. I would also like to express my appreciation to my committee members, Drs. Ann Austin and Kathy Piercy, for their assistance and support.

A special thanks goes to my family, friends, fellow students, and colleagues. Without your support, love, encouragement, and understanding, I could not have made it.

LaFray Kelley

CONTENTS

	Page
ABSTRACT.....	iii
ACKNOWLEDGMENTS.....	v
LIST OF TABLES.....	ix
LIST OF FIGURES.....	x
CHAPTER	
1. INTRODUCTION.....	1
2. REVIEW OF LITERATURE.....	7
Group Therapy.....	7
Curative Factors.....	7
Leadership Style.....	10
Research on Time-Limited Group Therapy.....	11
Summary of Literature on Group Therapy.....	13
Couples' Group Therapy.....	14
Curative Factors.....	14
Differences Between Traditional and Solution-Focused Groups.....	15
Summary of Literature on Couples' Group Therapy.....	16
Solution-Focused Therapy.....	16
Interventions.....	16
Outcome Research.....	19
Summary of Literature on Solution-Focused Therapy.....	21
Solution-Focused Couples' Therapy.....	22
Interventions.....	22
Summary of Literature on Solution-Focused Couples' Therapy...	24
Summary of Review of Literature.....	24

Purpose.....	25
Research Questions.....	26
3. METHODOLOGY.....	27
Pilot Study.....	28
Recruitment of Research Sample.....	30
Description of Sample.....	31
Measures.....	34
RDAS.....	34
KMS.....	36
Self-Report Goal Sheet.....	37
Research Design.....	38
Procedures.....	41
Development of Treatment Manual.....	41
Treatment Protocol.....	42
Analysis of Data.....	47
4. RESULTS.....	50
Research Question 1.....	50
Research Question 2.....	54
Research Question 3.....	56
Field Note Observations.....	60
Group Dynamics.....	60
Solution-Focused Factors.....	62
5. DISCUSSION.....	65
Summary of Findings.....	66
Research Question 1.....	67
Research Question 2.....	71
Research Question 3.....	72
Limitations of the Research.....	73
Implications and Recommendations.....	75
REFERENCES.....	80
APPENDICES.....	87
Appendix A. Treatment Manual	
Solution-Focused Couples' Group Therapy.....	88
Appendix B. Informed Consent Materials.....	116
Appendix C. Measures.....	120

Appendix D. Advertisement for Solution-Focused Couples' Group Therapy.....	124
---	-----

LIST OF TABLES

Table	Page
1 Data Collection Schedule.....	40
2 Session Foci and Measures.....	46

LIST OF FIGURES

Figure		Page
1	Pilot group participants' scores on the Revised Dyadic Adjustment Scale.....	29
2	Pilot group participants' scoring of progress toward individual goals.....	29
3	Pilot group participants' scoring of progress toward couple goals.....	30
4	Group 1 participants' scores on the Revised Dyadic Adjustment Scale.....	52
5	Group 2 participants' scores on the Revised Dyadic Adjustment Scale.....	52
6	Group 1 participants' scores on the Kansas Marital Satisfaction Scale.....	53
7	Group 2 participants' scores on the Kansas Marital Satisfaction Scale.....	53
8	Comparison of means on all measures.....	55
9	Group 1 participants' scoring of progress toward individual goals.....	57
10	Group 1 participants' scoring of progress toward couple goals.....	57
11	Group 2 participants' scoring of progress toward individual goals.....	58
12	Group 2 participants' scoring of progress toward couple goals.....	58

CHAPTER 1

INTRODUCTION

Solution-focused therapy is one of the models of brief family therapy that has come into prominence during the eighties and nineties. It is similar to strategic therapy in that the focus is not on the past and what "caused" the problem, but rather on how the problem can be solved. Strategic therapy, as developed at the Mental Research Institute in Palo Alto, was innovative in that it focused on problems, not causes. The therapist then introduced strategic interventions to provide new solutions to these problems and to change the behavior that maintained them (Nichols & Schwartz, 1995).

The development of solution-focused therapy took this change in problem emphasis a step further. Whereas strategic therapists looked for what was maintaining the problem, solution-focused therapists looked for "exceptions"--times when the problem was not happening--and expanded upon them. The focus was on the solution, not the problem, and the solutions came from the client, not the therapist.

Most of the leaders in the solution-focused movement worked at the Brief Family Therapy Center in Milwaukee (Nichols & Schwartz, 1995). Steve de Shazer and Insoo Kim Berg originated the idea of focused solution development and, along with Eve Lipchik, Michele Weiner-Davis, and

others, worked to develop and expand upon the solution-focused model. Bill O'Hanlon, although not affiliated with the center, collaborated with Weiner-Davis in elaborating on the previously laid groundwork. Other therapists (Adams, Piercy, & Jurich, 1991; Furman & Ahola, 1992; McKeel, 1996; Walter & Peller, 1992) have been interested in the solution-focused perspective and have researched, experimented with, and extended the model.

Walter and Peller (1992) defined solution-focused brief therapy as

a non-pathology oriented approach that assumes that people have the strengths and resources to find their own solutions but they have reached a point where they perceive themselves as stuck.... It [solution-focused therapy] believes that language is the source of personal and social reality and the means toward a future in which clients can perceive solutions. The therapist collaborates with clients to this end in a conversation characterized by therapist acceptance and curiosity about the client's present reality. The therapist asks questions about exceptions to the problem, existing and potential resources, and a future in which the problem does not exist. This conversation shifts the clients' reality toward one that includes both/and thinking and possible new options. (p. 69)

A premise of solution-focused therapy is that a therapist does not need to know much about the history or nature of the problem to facilitate the discovery of workable solutions. In fact, Walter and Peller (1992) stated that the implication is that "problem information is no longer necessary and, in fact, can be limiting in many cases" (p.7).

In describing the solution-focused approach, Berg (1994) stated that "solution-focused therapists believe it is easier and more profitable to construct solutions than to dissolve problems; it is also easier to repeat already successful behavior patterns than to try and stop or change existing behavior" (p. 10). Weiner-Davis (1992) and O'Hanlon and Hudson (1995) contrasted this approach with insight-based therapies. They asserted that a solution-focused orientation bypasses behavior analysis and offers concrete ways to change actions and points of view and that this model assumes that changes in insight and perception follow changes in behavior.

Walter and Peller (1992) emphasized the nonnormative basis of solution-focused therapy. They stressed that a solution-focused approach centers on what the client wants to be doing and not on a therapist's expert opinion of what the client should be doing.

Fundamental to the solution-focused approach is the principle of parsimony. Solution-focused therapists strive for simplicity in case conceptualization and therapeutic means. Berg and Miller (1992) explained that "the therapy proceeds with the most straightforward assumptions and strategies and adds complexity only as needed.... Most often, all that is needed to bring about dramatic changes are minimal interventions designed

primarily to get the patient going in the direction of the desired change" (pp. 9, 11). Solution-focused therapy is by nature brief, with the average number of sessions reported as four or five (Shoham, Rohrbaugh, & Patterson, 1995).

The present study was based on the assumption that this type of therapy could be effective as a couples' group therapy approach, although little if any research or writing has been done in this area. When working with couples, discussing the history of the problem often leads to defensiveness and assigning blame, resulting in what Furman (1998) calls a "problem vicious cycle." A solution-focused orientation allows the therapist to focus on success and opens up opportunities to compliment the couple on solutions they have tried that have worked. A "solution virtuous cycle" (Furman, 1998) is formed in which partners share credit rather than blame. This, in turn, sets the stage for better collaboration and discovery of more solutions.

Group therapy should work well with this orientation because working in a group opens up even more resources for solutions as couples share ideas and exceptions. For example, if partners were having difficulty finding exceptions to their problems, perhaps others in the group would have had similar experiences and possible solutions.

This collaborative group approach, rather than the therapist's acting as "expert," would further reinforce the concept of the couples' actively finding and experimenting with workable solutions.

There has been considerable theory-building and research on group therapy process and curative factors both with individuals and couples (e.g., Berman-Rossi, 1993; Coche, 1995; Coche & Coche, 1990; Ettin, Heiman, & Kopel, 1988; Reichline & Targow, 1990; Snyder & Guernsey, 1993; Sundel & Lawrence, 1977; Yalom, 1975, 1995; Yalom & Yalom, 1990). These studies have outlined therapist tasks, stages of group development, and tasks of participants. They have also offered practice guidelines and postulated curative factors. Information on solution-focused therapy with individuals and couples also is plentiful (Berg, 1994; Berg & Miller, 1992; de Shazer, 1985, 1988, 1994; Lipchik & Kubicki, 1996; O'Hanlon & Hudson, 1994, 1995; Walter & Peller, 1992; Weiner-Davis, 1992). However, outcome research is rather sparse (Adams et al., 1991; Beyebach, Morejon, Palenzuela, & Rodriguez-Arias, 1996; De Jong & Hopwood, 1996; McKeel, 1996; Metcalf, Thomas, Duncan, Miller, & Hubble, 1996).

A search of the literature failed to locate any outcome research dealing with a solution-focused model used with couples' group therapy. In an increasingly

cost-conscious mental health climate, time-limited group therapy offers a way to serve more clients and produce more benefits per dollar spent. Because it is often difficult to retain both members of a couple for extended therapy, the brief orientation of the solution-focused model would be most efficient. If research suggests that it is effective, short-term solution-focused couples' group therapy has the potential to fill a need in the mental healthcare delivery system. The purpose of this study was to determine whether short-term solution-focused couples' group therapy has a positive effect on overall marital satisfaction and specific problem resolution.

CHAPTER 2

REVIEW OF LITERATURE

A review of pertinent literature reveals information on group therapy in general, couples' group therapy, solution-focused therapy in general, and solution-focused therapy with couples. The review revealed only one article on solution-focused group therapy and no information on solution-focused group therapy with couples. The following is a brief summary of information on these topics to provide background for this study. Each section reviews factors of the modality and research related to the factors.

Group Therapy

Curative Factors

A definitive work on group psychotherapy is The Theory and Practice of Group Psychotherapy (Yalom, 1975, 1995). Subsequent work in the field has been built upon some of the principles postulated by Yalom, who enumerated conditions for change and mechanisms of change facilitated by group work. These include: (a) instillation of hope, (b) universality, (c) imparting of information, (d) altruism, (e) corrective recapitulation of the primary family group, (f) development of socializing techniques, (g) imitative behavior, (h) interpersonal learning,

(i) group cohesiveness, (j) catharsis, and (k) existential factors. Due to the short-term nature and future orientation of a solution-focused couples' group model, reworking of family of origin issues, catharsis, and existential factors are not relevant goals in this study. However, the other curative factors proposed by Yalom are important elements of this model. Factors proposed to be of primary significance are imparting of information, imitative behavior, and group cohesiveness.

Imparting of information. Apgar and Coplon (1985), as well as Ettin et al. (1988), discussed the role of psychoeducation in structured groups. Apgar and Coplon cited research that suggests "specific behavioral and attitudinal changes are acquired in [these] groups" (p. 142) and that psychoeducational group work is the beginning of a learning process that continues beyond the life span of the group. Ettin and colleagues presented a model used with latency incest and smoking cessation groups which incorporated psychoeducation with group process. They stated that the group provides an arena to "disseminate knowledge while ... simultaneously learning from the phenomenological experiences of the members" (p. 206) and suggested that "such a group may go a long way toward deconditioning dysfunctional patterns and reconditioning a more healthful responsivity" (p. 224).

This reconditioning was expected to play a significant role in solution-focused couples' group process.

Imitative behavior. Yalom (1975, 1995) stated that "even if the specific imitative behavior is short-lived, it may function to help the individual 'unfreeze' by experimenting with new behavior" (p. 17). This benefit was expected as a result of working with a group of couples. An auxiliary effect of couples' group work was noted by Framo (cited in Reichline & Targow, 1990): "One of the reasons couple group therapy is the treatment of choice for premarital, marital, separation, and divorce is that the other couples provide not only models of how marital struggles can be worked out, but also models of what to avoid" (p. 231).

Group cohesion. Yalom (1975, 1995) and others (Berman-Rossi, 1993; Coche & Coche, 1990) have stressed the importance of passing through specific stages to enhance group cohesion and strengthen the work of the group. At first glance, it would seem that group cohesion might be reduced in a short-term group; however, Daste and Cox (1985) reported that in their study of a time-limited (nine session) children's self-concept group, the short-term nature of the group actually contributed to cohesion. They stated that "members eagerly sought out similarities in backgrounds, shared experiences,... talked about target

behavior and compared goals for themselves. It appeared as though fewer meetings had a stabilizing effect on the group. Their awareness of time encouraged members to work quickly toward their goals" (pp. 143-144). They stated that the group leader had to be more active and directive than in open-ended groups to facilitate this cohesion.

Leadership Style

Directive leadership. Directive group leadership is cited as an important component in the success of time-limited therapy groups (Daste & Cox, 1985; Rawlings & Gauron, 1973; Rotholz, 1985). Dies (1985) cautioned that this type of leadership can be perceived as manipulative, but indicated that this is not inevitable. He gave suggestions for setting limits and introducing structure and contrasted behaviors of "the manipulator" and "the facilitator." He introduced the results of an "informal study" which indicated that "process commentary, reflection, interpretation, introduction of structured exercises, and so forth were often regarded as helpful and not necessarily manipulative and controlling" (p. 449).

Therapist tasks. Yalom and Yalom (1990) stated that the therapist's main tasks in brief group therapy are to provide group structure and establish and reinforce group norms. They asserted that another important aspect is that the therapist assist participants in setting

realistic goals and in tracking these goals throughout the course of the group.

Establishing group policies. Participation and self-disclosure are influential factors in a successful group experience. Coche (1995) suggested using group psychotherapy policies that emphasize the importance of confidentiality and active participation in the group. Nelson-Jones (1992) offered techniques of group leadership that encourage self-disclosure and participation. These included get-acquainted activities, modeling appropriate self-disclosure, stressing the value of contributions to the group, and redirecting disclosures that are focused on other people rather than being self-referent. These methods have worked well with individually-oriented groups, according to Nelson-Jones, and therefore should be applicable to couples' groups.

Research on Time-Limited

Group Therapy

Rotholz (1985) reported positive results in a single session group conducted by a clinical social worker in the waiting room of a hospital out-patient department. The population consisted of insulin-dependent patients ages 18-45 who attended the Metabolic Day Center on a regular basis. The author reported that even in a single session, the group moved through beginning, middle, and ending

phases of group process. The experience was judged to be helpful as measured by feedback from clinic staff and group participants. Rotholz also stressed the importance of directive leadership. This study, along with the anecdotal success reported by Daste and Cox (1985), supports the notion that positive results can be achieved with group therapy in a limited number of sessions.

A similar conclusion was reached by Rawlings and Gauron (1973). They presented their results working with a model they called "accelerated time-limited group therapy." This model was used in an in-patient hospital setting and consisted of ten 2-hour sessions over 5 weeks with a marathon 8-hour session as the next-to-the-last meeting. They reported that even with this group of patients with chronic problems, treatment "proved beneficial for at least one-half of the members" (p. 69). They concluded that those who did not respond to this type of treatment "apparently do not improve with more extensive group psychotherapy either" (p. 69) and suggested that individual therapy might be more appropriate for these patients. Again, directive group leadership was cited as an important factor.

Reporting on research using a time-limited behavioral group model, Sundel and Lawrence (1977) stated that 6 months after group termination, four out of five clients

achieved or closely approximated their goals as evaluated by therapists and individual clients. In subsequent groups, 15 out of 17 members rated problems as "substantially" to "fully" alleviated. Most successful clients reported applying concepts and techniques learned in the group to other contexts.

Summary of Literature on Group Therapy

In summary, several curative factors were reported to be involved in group work. From a solution-focused point of view, the most important are imparting information, imitative behavior, and group cohesiveness. Through imitating positive behaviors that they had observed or heard reported and through reporting their own successes, participants could envision a hopeful future and expand exceptions to their problem patterns.

Research suggested that even in short-term groups, group cohesiveness and positive peer pressure can be influential components of the change process. Participation and self-disclosure by group members and active group leadership by the therapist are significant factors in positive outcome.

Couples' Group Therapy

Curative Factors

Reichline and Targow (1990), after years of experience, concluded that "the problems of couples could be more effectively treated in groups" (p. 232) and that the optimum number of couples in the group was four. They stated that "a couples group offers maximal growth for the individual, as well as the relationship" (p. 232) because clients alternate between client and observer roles.

Budman and Clifford (1979) would seem to concur when they presented a case for short-term couples' group therapy as an effective part of preventative health maintenance organization (HMO) care. They described a 15-session program at the Harvard Community Health Plan. They related their findings concerning curative factors as follows:

We chose to treat these couples in a group rather than in a conjoint context, because we felt that a number of potent factors are present in a couples group that are not present in conjoint therapy. First, being part of a group allows a couple to observe and perhaps model aspects of other marital interactions. A couple may also observe their own interaction mirrored in another couple's relationship. This may help them to objectify and to begin to modify dysfunctional patterns in their interaction. Also quite important in a couples group is the opportunity to receive feedback about how one is relating to other group members and to one's spouse. When this feedback comes only from one's spouse, it may be perceived as slanted or unobjective. When it comes from a therapist in conjoint treatment, it may be seen as unfair or

biased in favor of the spouse. The impact of feedback may be much greater if it is received from group members. (pp. 419-420)

In presenting a case example from a couples' treatment group for marital and sexual dysfunctions, Metz and Weiss (1992) concluded that "effective progress can be made in a brief conjoint group therapy format" (p. 187). They attributed this success in part to "peer persuasion in combination with the peer support which we believe comprises a distinct advantage to the group treatment modality over individual and conjoint formats" (p. 175). Their format included an initial homework report followed by a positive growth-oriented minilecture. Coche (1995) as well as Mandell and Birenzweig (1990) reported similar success with a mixed education/discussion format.

Differences Between Traditional and Solution-Focused Groups

Coche and Coche (1990) discussed stages of group development, membership criteria, structured exercises, and development of specific communication skills in relation to couples' groups. Yalom (1975) asserted the importance of corrective recapitulation of the primary family group, catharsis, and existential factors in group process.

However, according to Hardenburg (1994), these ideas are not compatible with a solution-focused orientation

which stresses commitment to the duration of the treatment as the only membership criterion and does not assume stages of group development. The skills taught are those needed to maintain a solution-focused outlook and to encourage other group members to do the same. Group process is guided, but there are no structured skill-building exercises such as role-playing in this treatment model.

Summary of Literature on

Couples' Group Therapy

The literature suggests that many therapists believe that a couples' group is most effective in treating marital problems. Positive peer pressure and peer support can influence the couple to use more functional relationship skills. Feedback from the group is often perceived as less biased than feedback from the spouse or the therapist. Also, observing the interaction in other relationships may give couples examples of what to do and what not to do in their relationships.

Solution-Focused Therapy

Interventions

Specific interventions used by practitioners of solution-focused therapy include: goal formation criteria

(Berg & Miller, 1992; Walter & Peller, 1992; Weiner-Davis, 1992), the formula first session task (de Shazer, 1985), the miracle question (Berg & Miller, 1992; de Shazer, 1994), scaling questions (Berg & Miller, 1992; de Shazer, 1994), EARS method of enhancing positive change (Berg, 1994), and resource mapping (Furman, 1998). Each of these is discussed below.

Well-formed goals. Berg and Miller (1992) suggested the following criteria for well-formed goals. They should be (a) salient to the client, (b) small, (c) concrete, specific, and behavioral, (d) indicate the presence rather than the absence of something, (e) represent a beginning rather than an end, (f) be realistic and achievable to the client, and (g) be perceived as involving "hard work."

Formula first session task. The formula first session task is given as homework at the conclusion of the first session. This task consists of the following instructions: "Between now and next time we meet, we would like you to observe, so that you can describe to us next time, what happens in your (pick one: family, life, marriage, relationship) that you want to continue to have happen" (de Shazer, 1985, p. 137).

Miracle question. The miracle question is useful in goal setting in that it requires the couple to envision a future without the problem. As described by Berg and

Miller (1992), the miracle question consists of the therapist proposing the following scenario:

Suppose that one night, while you are asleep, there is a miracle and the problem that brought you into therapy is solved. However, because you are asleep you don't know that the miracle has already happened. When you wake up in the morning what will be different that will tell you that the miracle has taken place?... What else? (p. 13)

In describing the "miracle," clients begin to behaviorally delineate their goals.

Scaling questions. Scaling questions (Berg & Miller, 1992) in which participants assign a number (e.g., 6 on a scale of 1 to 10) to their progress also are valuable in goal formulation and assessment. de Shazer (1994) stated that "scaling questions allow both therapist and clients to jointly construct a bridge, a way of talking about things that are hard to describe -- including progress toward the client's solution" (p.92).

EARS. Berg (1994) explained a method of positive reinforcement of exceptions using the EARS acronym. EARS stands for Elicit, Amplify, Reinforce, and Start over. In her work, she uses these steps to assist clients in elaborating on the exceptions to the problem that they have noticed: (a) elicit: "What's better? How did you do that?"; (b) amplify: "Who else noticed? What did others do differently? How did it affect the rest of your day? What difference did it make in other areas and

relationships?"; (c) reinforce: with posture, tone of voice, and attitude; and (d) start over: "What else is better?"

Resource mapping. Resource mapping as explained by Furman (1998) involves partners' mapping with each other all possible resources that can be used to help them progress toward their goals. Resources might include personal strengths, family, friends, religion, books, movies, heroes, role models, and so forth.

Outcome Research

Outcome research is available on one of these interventions: the formula first session task (FFST). Adams et al. (1991) compared treatment conditions that included the FFST followed by problem-focused therapy, the FFST followed by solution-focused therapy, and a problem-focused intervention followed by problem-focused treatment. They reported that after 1 week, the groups receiving FFST were significantly higher statistically on measures of compliance, clarity of treatment goals, and improvement in presenting problem. There were no statistically significant differences between the groups on family optimism after 1 week or on success of therapy after 10 sessions as evaluated by therapists, participants, and independent observers.

Summarizing outcome research on solution-focused

brief therapy, McKeel (1996) related that only a few studies of the model exist, but that results were generally favorable. He reported that research showed that most clients accomplish their treatment goals.

Additionally, process studies suggested:

1. Pretreatment improvement is common. However, therapists report that exploring pretreatment change does not often lead to therapeutic progress.
2. Presuppositional questions [questions that communicate an expectation or belief] help clients develop new views of their situation.
3. Clients typically cooperate with the FFST and report improvements in their second session.
4. Therapists find scaling questions to be an effective technique for monitoring treatment progress.
5. Client-therapist collaboration is associated with treatment success.
6. Therapists' solution-talk is typically followed by the report of change. (McKeel, 1996, p. 264)

An overview of research on solution-focused therapy by the Salamanca Group (Beyebach et al., 1996) suggested that emphasis on pretreatment change, clear goals, and promoting clients' internal locus of control were conducive to positive treatment outcome. In addition, the authors concluded that therapy can be successful even when clients do not complete assigned tasks.

In their qualitative analysis of client and therapist perceptions of solution-focused therapy, Metcalf et al. (1996) reported that results were supportive of the solution-focused tenets that change is constant and that empowering clients' existing resources and encouraging

them to seek their own solutions is conducive to positive change.

De Jong and Hopwood (1996) reported that their study of clients at the Brief Family Therapy Center confirmed the findings of earlier studies by Kiser (1988) and Kiser and Nunnally (1990) (cited in De Jong & Hopwood, 1996). They stated that "more than three-fourths of clients receiving solution-focused therapy either fully met their treatment goals or made progress toward them [and] this level of effectiveness occurred over an average of 3.0 sessions" (p. 294).

Summary of Literature on Solution-Focused Therapy

To summarize, clients in solution-focused therapy generally reported improvement in the presenting problem. Therapists found that scaling questions were an effective way to monitor client progress. Clear goals, promoting the client's internal locus of control, presuppositional questions, therapist emphasis on solutions, and client-therapist collaboration seemed to be important elements in goal accomplishment. A future orientation and amplification of exceptions were emphasized through interventions such as the formula first session task and the miracle question.

Solution-Focused Couples' Therapy

Interventions

Focus on exceptions. Solution-focused therapy for couples follows the same general principles as for individuals. Often, little attention is paid to problematic interaction sequences. An example is de Shazer's description (cited in Shoham et al., 1995, p. 154) of his work with a bickering couple: "At no point during any of the three sessions did we discuss bickering, the pattern(s) involved, its possible causes, or its possible meaning. We only talked about what they did when they did not bicker."

Solution-focused work with couples emphasizes the interventive value of interviewing alone, such as asking questions to amplify exceptions and construct a hopeful future. Hudson and O'Hanlon (cited in Shoham et al., 1995) explained their approach and the reasoning behind it:

Whatever people's experiences at the moment, they are likely to feel that they have felt the same way for a long time, even if that has not been the case.... We try to coax people out of the global negative thinking about the marriage by asking about when things were better. This not only tends to move them from thinking that everything is negative to adopting a more positive view, but also helps us identify what has worked in the past.... To locate strengths and resources that the couple has but has neglected, we ask about what was happening when things were better, we hold positive strength-oriented assumptions, and we ask for exceptions to the rule of the problem.

Implicit in our questions and comments is an assumption that the couple has resources for change. (pp. 47, 50)

In addition to the interventions from solution-focused individual therapy, specific interventions are recommended for solution-focused work with couples. They involve using competencies from other contexts (O'Hanlon & Hudson, 1995) and ideas to "keep the ball rolling" (Weiner-Davis, 1992).

Utilizing competencies from other contexts. O'Hanlon and Hudson (1995) gave examples of using skills from other areas of competence to improve the couple's relationship. They suggested noticing skills that work well on the job or in friendships and using them to improve the relationship between partners. They also suggested remembering patterns from early in the relationship that resolved conflict and increased feelings of love and repeating these patterns.

Ideas to keep the ball rolling. Once the couple feels that they are on track, they are ready to learn ideas to keep the ball rolling (Weiner-Davis, 1992). These include identifying changes, sharing the credit, describing how to keep things going, and planning ways to overcome challenges and reverse backsliding.

Summary of Literature on
Solution-Focused Couples' Therapy

To summarize, in solution-focused couples' work, questions which amplify exceptions are used to construct a hopeful future. Emphasis is placed on the strengths and resources of the couple that are conducive to positive change. Couples are encouraged to use competencies from other contexts, ideas that have worked for them in the past, and contingency plans for the future to ensure their continued success. Therapists and clients reported that using this model, clients were able to progress toward and reach their goals a good percentage of the time.

Summary of Review of Literature

The preceding review of literature revealed positive outcomes for couples' group therapy and solution-focused couples' therapy. Curative factors in group work included imparting information, imitative behavior, and group cohesiveness. Research suggested that even in short-term groups these factors were at work and that directive group leadership facilitated their development. Several therapists reported that they believe a couples' group is most effective in treating relationship problems. Clients are able to observe and learn from interactions in other relationships and often perceive feedback given by group

members as less biased than feedback from their partner or a therapist.

In solution-focused therapy, successes rather than problems are the main focus. Exceptions to problem patterns are actively elicited and expanded through the formula first session task and other interventions. A future orientation is cultivated with the miracle question and maintained through interventions that emphasize resources and ways to keep the ball rolling toward positive change.

Outcome research on solution-focused therapy suggested that empowering clients' existing resources and encouraging them to seek their own solutions was conducive to positive change. Most clients reported accomplishing or making progress toward their treatment goals.

Thus, a review of relevant literature suggested that a solution-focused couples' therapy group would help couples make positive changes toward their goals. An additional assumption was that progress toward goals would tend to increase marital satisfaction. The purpose of the present research was to test these suppositions.

Purpose

The purpose of this study was to determine whether short-term solution-focused couples' group therapy has a

positive effect on marital satisfaction and specific problem resolution.

Research Questions

1. Do couples who attend a short-term solution-focused couples' therapy group report increased marital satisfaction?
2. Do couples who attend a short-term solution-focused couples' therapy group report progress toward their individual and couple goals?
3. Do partners experience similar results in marital satisfaction and goal attainment?

CHAPTER 3

METHODOLOGY

The present research studied the effects of a solution-focused couples' therapy group on marital satisfaction and goal achievement. The main premise was that an emphasis on enhancing solution patterns using solution-focused interventions combined with the encouragement and positive peer pressure of a group would be beneficial for couples' therapy.

Solution-focused therapy is based on a collaborative approach and on clients' actively finding their own solutions. Sharing resources with other couples seems a natural outgrowth of this method. The purpose of this study was to begin investigation of whether or not this approach would be useful with couples. Specifically, does it increase marital satisfaction and facilitate accomplishment of individual and relational goals? The supposition is that if a solution-focused couples' group is effective in enhancing marital satisfaction and facilitating couple goal accomplishment, it could be an economical healthcare option in the alleviation and prevention of relationship problems.

Pilot Study

A pilot group was obtained by advertising a relationship enhancement group to be held at the Family Life Center at Utah State University (see Appendix D for advertisement). Advertisements in the Herald Journal, flyers, and church announcements were used on the Utah State University campus and throughout the Logan area. This approach resulted in nine couples enrolling, four couples attending the first session, and three couples attending all four sessions.

Interventions in the pilot group seemed to be successful as evidenced by progress on goal sheets and the Revised Dyadic Adjustment Scale (RDAS; Busby, Christensen, Crane, & Larson, 1995) and were retained in their original forms. A visual inspection of the data revealed a trend in the expected direction and so further research with the model seemed warranted. Data are displayed in Figures 1, 2, and 3.

Feedback from pilot group participants was positive with many commenting that they were comfortable in the group because it did not focus on problems. Some group members had been married only a short time and some for 20 years or more. Couples had developed solution patterns which they shared with the group and which were sometimes adopted by other members of the group.

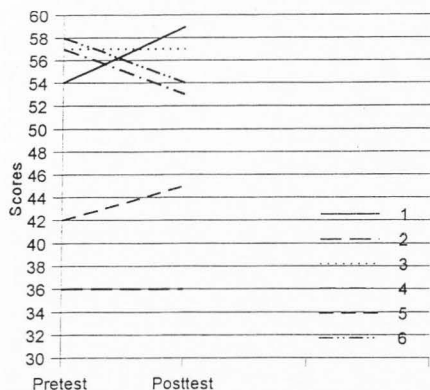


Figure 1. Pilot group participants' scores on the Revised Dyadic Adjustment Scale.

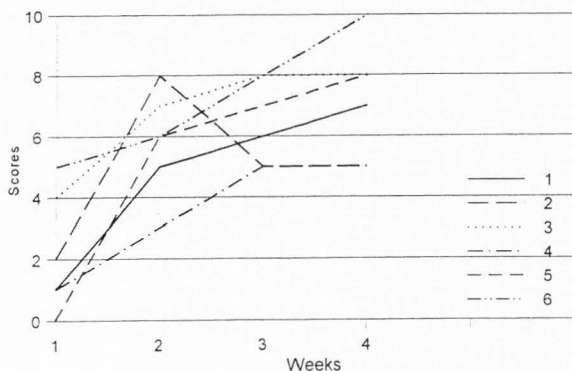


Figure 2. Pilot group participants' scoring of progress toward individual goals.

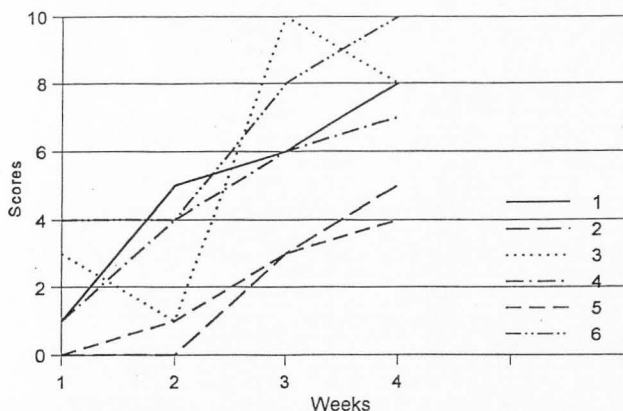


Figure 3. Pilot group participants' scoring of progress toward couple goals.

Recruitment of Research Sample

The first experimental group was obtained using the same advertising procedure used with the pilot group. This method resulted in eight couples responding by phone, four couples attending the orientation session, and three couples attending all four sessions. The intervention appeared to exhibit potency with this nonclinical sample and further research with a clinical sample was conducted.

A second experimental group was obtained by advertising a relationship enhancement group available to clients at Weber Human Services in Ogden. Announcement of the group was made by flyers posted throughout the

building, resulting in an enrollment of four couples. Due to fortunate increases in work hours, only two couples completed all four sessions. Only the data for these two couples will be discussed.

Prior to testing, an orientation session was held for each group to explain to the couples the research design and time commitment involved. A drawing for a free dinner for two was used as an incentive for couples to complete the entire program. Arby's coupons were given to those who did not win the drawing.

Description of Sample

The sample included 5 heterosexual couples divided into two groups. The first group was recruited by advertising a relationship enhancement group to be held at Utah State University in Logan. Three couples participated in this group. All were Caucasian and married.

Couple 1 had been married 3.5 years. They had one child who was 2 years old. Their reported income level was \$10,000-15,000 per year. They reported no previous therapy. The husband was 26 years old with 15 years of education. He was a college student and also was employed 30 hours a week. The wife was 27 years old with 15 years of education. She was a homemaker and also was self-

employed as a full-time daycare provider.

Couple 2 had been married 7 years. They had two children, ages 4 and 6 years. They previously had received couple therapy. They reported their income as above \$50,000 a year. The husband was 38 years old with 16 years of education. He was employed full-time. The wife was 34 years old with 15 years of education. She reported that she was a homemaker and was also employed part-time as a medical technician.

Couple 3 had been married 19 years. They had four children. Their oldest child was 18 years old and their youngest was 7 years old. Their yearly income was above \$50,000. They previously had received couple therapy. The husband was 45 years old with 16 years post-high school education and was employed full-time in the medical profession. The wife was 44 years old with 6 years post-high school education. She was employed part-time.

The second group consisted of participants obtained by advertising a relationship enhancement group to the clientele at Weber Human Services in Ogden. Two Caucasian couples participated.

Couple 1 had been married 10 years. It was a second marriage for both. They reported no previous couple therapy, but the wife had received therapy in the past and was currently a client of the researcher in an individual

therapy setting. The husband was 59 years old and unemployed. He was receiving Social Security financial assistance due to chronic arthritis. His first wife had died and he had three adult children who were not living with the couple. He had 11 years of education with additional training in auto mechanics. The wife was 51 years old and had 14 years of education. She was a homemaker and student working on her bachelor's degree. She also worked part-time as a substitute teacher. She was receiving disability assistance due to epileptic seizures that were controlled by medication. She had been divorced and had a 13-year-old daughter who was living with the couple. They reported their combined income as approximately \$5,000 annually.

Couple 2 had been living together for 6 years, but were not married. They reported no previous therapy, but the wife was receiving individual therapy as a client of the researcher. Their reported yearly income level was \$5,000-10,000. The male was 34 years old and had 12 years of education. He was employed in construction. He had two children from a previous marriage, but they were not living with the couple. The female was 34 years old with 12 years of education. She was a homemaker and had two children ages 5 and 11 years from a previous marriage. These children were living with the couple.

Measures

Three research questions were investigated:

1. Do couples who attend a short-term solution-focused couples' therapy group report increased marital satisfaction? Marital satisfaction was measured using the RDAS (Busby et al., 1995) and the Kansas Marital Satisfaction Scale (KMS; Schumm, Jurich, & Bollman, 1990), two widely used measures in the field of marital therapy. Both are described below (see Appendix C for all measures).
2. Do couples who attend a short-term solution-focused couples' therapy group report progress toward their individual and couple goals? Progress toward goals was monitored by continuous self-report on a scaling chart in keeping with a solution-focused orientation.
3. Do partners experience similar results in marital satisfaction and goal attainment? Partners' scores on all measures were examined for similarities in trend and magnitude of change.

RDAS

The Dyadic Adjustment Scale (DAS; Spanier, 1976) was designed to measure components of marital adjustment. Subscales measure consensus on matters of importance to marital functioning, dyadic satisfaction, dyadic cohesion,

and affectional expression. The instrument can be used to measure general marital satisfaction or the subscales can be used independently and the reliability and validity of the measure is still retained. The DAS is frequently used by both researchers and clinicians and has particular value since it is relatively short (32 items), yet is multidimensional (Busby et al., 1995).

The RDAS (Busby et al., 1995) was designed to improve upon the DAS by following the standards of construct hierarchy and selecting out items that were homogeneous. Questions were constructed to measure dyadic consensus, cohesion, and satisfaction.

Similar to the DAS, the RDAS is a paper and pencil self-administered instrument consisting of 14 items. Questions have a 6-point Likert-type response format ranging from always agree to always disagree.

Busby and colleagues (1995) reported that the RDAS is a good representation of the domains of the DAS with fewer than half the items. In previous studies with the DAS, construct validity was evidenced by correlation with another popular measure of marital adjustment, the Locke-Wallace Marital Adjustment Test (MAT; Locke & Wallace, 1959). The correlation coefficient between the RDAS and the MAT was .68, whereas the correlation coefficient between the DAS and MAT was .66.

Discriminant analyses comparing the RDAS and the DAS revealed equal ability to classify cases as distressed or nondistressed. Both correctly classified 81% of the cases. Internal consistency as measured by Cronbach's alpha for the RDAS was .90 (Busby et al., 1995).

KMS

The KMS (Schumm et al., 1990) is a self-report measure consisting of three questions assessing satisfaction with husband or wife as a spouse, with the marriage in general, and with the relationship with the spouse. Response categories have a 7-point format ranging from extremely dissatisfied to extremely satisfied. Cronbach's alpha ranged from .84 to .98 on populations throughout the state of Kansas. Test-retest correlations of .71 were reported over a 10-week interval with a range of .62 to .72 over 6 months.

Schumm and colleagues (1990) reported statistically significant correlations between high and low scores on the KMS (Schumm et al., 1990) and the DAS (Spanier, 1976) satisfaction subscale. All correlations were statistically significant with the exception of "How often do you argue with your spouse?" and ranged from .76 to .39.

Self-Report Goal Sheet

The self-report goal sheet was developed for use in this study and was patterned after scaling questions common in solution-focused therapy (Berg & Miller, 1992; de Shazer, 1994). This goal sheet was used to monitor progress toward goals set by group participants. Group instruction was given on developing well-formed behavioral goals. The group then split into couples and each couple was asked to discuss goals for their relationship. Participants were asked to formulate for themselves a specific behavioral goal that would strengthen the relationship, to collaborate on a couple goal, and to list these goals on a progress report worksheet.

Advancement toward goals was recorded weekly at the beginning of each session using a 0 to 10 scale with 0 being no progress toward the goal and 10 representing total goal accomplishment (see Appendix C for worksheet). Each participant was asked to scale progress toward individual and couple goals without conferring with their partner. Because the scaling of progress was performed within the group context and was observed by the researcher, independence was assumed.

The use of self-report measures in the present study was guided by the rationale cited by De Jong and Hopwood (1996) in their outcome research on solution-focused

therapy. They contend that because "solution-focused therapy works within the client's frame of reference, respecting the client's categories,...research about the model must somehow do the same. [Thus,]...research based on standardized, universal, scientific categories is suspected of not respecting different client 'realities'" (p. 294). They stress the importance of using measures such as scaling questions that are based on clients' rather than therapists' perceptions of progress and satisfaction with therapy.

Kazdin (1982) stated that self-report "often is an important measure because the person's private experience may be relevant to the overall problem [and] ... may represent a crucial dimension in its own right.... Hence, in most intervention studies, verbal reports are solicited that include self-report ratings" (pp. 36-37). In the present research, standardized self-report measures as well as client scaling of progress measures were used.

Research Design

This study utilized a single-case research design. This design seemed most appropriate because solution-focused couples' group therapy is a new type of treatment and the research is exploratory in nature. Kazdin (1982) stated that this type of design is useful in clinical

research and has been influential in the development and refinement of psychotherapy techniques. He asserted that single-case designs may be of special relevance to clinical work because interventions are evaluated under the circumstances in which they will be implemented rather than in academic or research situations. Kazdin's contention that "investigation of groups and conclusions about average patient performance may distort... the effects of treatments on individuals... [and] that experimentation at the level of individual case studies may provide the greatest insights in understanding therapeutic change" (p. 14) has special relevance to the development of a solution-focused couples' group treatment plan.

Kazdin (1982) gave suggestions to improve internal validity in this type of design. These included using objective measures such as self-report inventories rather than anecdotal reports from therapists, assessing on multiple occasions including pretreatment, using several cases rather than just one, and taking into account the immediacy and magnitude of change when analyzing results. These guidelines were followed in the present study.

The research utilized a multiple-baseline design. Each individual served as his or her own control and represented a separate AB design. The replication of

intervention effects was across participants.

The design incorporated continuous assessment using the KMS (Schumm et al., 1990) to establish a baseline and to allow visual inspection for trend. The RDAS (Busby et al., 1995) was administered as a pre- and posttest to control for test sensitization. Similar trends in scores on both measures would serve as evidence of internal validity. Table 1 summarizes the data collection schedule for all measures.

The design began with repeated measures of baseline performance for each person using the RDAS (Busby et al.,

Table 1

Data Collection Schedule

Measure	Week							
	1	2	3	4	5	6	7	8
RDAS	X		X			X		X
KMS	X X	X X	X	X	X	X		X
Goal Sheet			X	X	X	X		

1995) and the KMS (Schumm et al., 1990). The RDAS was administered at the time of enrollment, at the beginning of the first session, and at the conclusion of the fourth session for both groups. A follow-up using the RDAS was given at week 8. The KMS was administered nine times: four times before sessions began in order to establish a baseline and four times during the course of treatment. Baseline assessments were biweekly; assessments during treatment were weekly. The KMS was also given as a follow-up on week 8.

The beginning of assessment was staggered for the two groups. After baseline assessments, treatment began for each group. When group sessions began, the self-report goal sheet was added to the assessment schedule. Goal progress was scaled during the 4 weeks of treatment.

Procedures

Development of Treatment Manual

Solution-focused principles and techniques were used to develop a treatment manual. Where applicable, ideas from the literature on group therapy were also incorporated. Because solution-focused therapy differs in basic orientation from psychodynamic and long-term or open-ended group psychotherapy, some of the techniques common in these therapies were not applicable. Unlike

traditional couples' groups, communication skills were not taught in the solution-focused couples' group; rather, the emphasis was on finding and expanding solution patterns in the relationship and helping others do the same (Hardenburg, 1994).

Treatment Protocol

Slight revisions in the treatment manual were made after the pilot study was conducted. Text was edited for clarity and reformatted for ease of use. Interventions were retained in their original form (see Appendix A: Treatment Manual for Solution-Focused Couples' Group Therapy for a more detailed discussion of treatment procedures). The KMS was added to the assessment schedule to establish a baseline and allow a closer scrutinization of trends.

Field notes were taken by the researcher during the course of the treatment. Verbal as well as written feedback was solicited from participants. Notes included a summary of the session, impressions of the researcher, and comments from group members.

Solution-Focused Couples' Group Therapy was designed to be a four-session relationship enhancement program. The group used a mixed education and discussion format that has been used successfully in other group programs (Apgar & Coplon, 1985; Coche, 1995; Mandell & Birenzweig,

1990). The sessions took place over a 4-week period and lasted 90 minutes each. Each session involved an assessment of current functioning, a report of homework from the previous session (in the first session, a welcome and orientation took the place of this segment), a "lecturette" on the focus of that session (Coche, 1995), an in-session task and discussion, and assignment of a homework task. One- or two-page discussion guides were given to participants to facilitate the in-session discussion and to remind them of the homework task.

Session 1. As outlined in the treatment manual (see Appendix A), the first group session was devoted to presentation of principles of goal setting aimed at improving the relationship. Group policies on confidentiality and participation were discussed and an informed consent form (see Appendix B) was signed. Two assessments (see Appendix C), the Revised Dyadic Adjustment Scale (RDAS; Busby et al., 1995) and the Kansas Marital Satisfaction Scale (KMS; Schumm et al., 1990), were administered at the beginning of this session.

A lecturette was given presenting the criteria for well-formed goals (Berg & Miller, 1992; Walter & Peller, 1992; Weiner-Davis, 1992). Emphasis was placed on making goals specific, behavioral, and attainable. The group was then split into couples and used a discussion guide

then split into couples and used a discussion guide (Furman, 1998) to set individual goals that would strengthen their relationship and also to collaborate on a couple goal. Each couple was asked to do a baseline scaling of goals. These goals were then shared with the group during a group discussion. Group members were encouraged to validate and support one another in reaching their goals. Homework was the formula first session task, which involves noticing things in the relationship that the couple desires to continue (de Shazer, 1985).

Session 2. Session 2 focused on replacing problem patterns with solution patterns. The KMS (Schumm et al., 1990) and a scaling question on individual and couple goals were given at the beginning of this session and each subsequent session. The RDAS (Busby et al., 1995) was not readministered until the final session and was also used as a posttest.

Next, the homework task was processed as a group. The purpose of this intervention was public acknowledgment of exceptions to problems and amplification and validation of things that are going right.

The lecturette for this session focused on the concept of problem and solution cycles (Furman, 1998) and ideas for interrupting problem patterns (Weiner-Davis, 1992). Group discussion on the miracle question as

describing what would be happening when their problems were solved. The purpose of this intervention was to instill hope and introduce a future orientation. Homework was noticing positive change and strategies used for problem interruption.

Session 3. The objective of session 3 was enhancing positive change by amplifying exceptions. At the beginning of the session, the KMS (Schumm et al., 1990) and behavioral goal scaling were completed.

The lecturette included a presentation of Berg's (1994) EARS concept (elicit, amplify, reinforce, start over) as a way to enhance positive change. The group then processed the homework task using these principles.

Next, the concepts of resource mapping (Furman, 1998) and using competencies from other contexts (O'Hanlon & Hudson, 1995) were introduced. Couples met together and each participant completed a resource map for his or her partner (see Appendix A for example). A group discussion followed with each person describing the resources of his or her partner. At the close of the session, an assignment involving utilizing competencies from other contexts was given.

Session 4. Session 4 focused on reviewing concepts from previous sessions and discussing ways to keep on track (Weiner-Davis, 1992). At the beginning of the

session, the KMS and goal scaling sheet were again completed. The homework task was processed as a group.

This session's lecturette presented ideas to keep the ball rolling (Weiner-Davis, 1992). Partners met together to discuss which of the ideas might be most applicable for them. Next, a group discussion focused on sharing credit (Furman, 1998). Each participant shared with the group ways in which his or her partner had offered help and support with goal accomplishment. The RDAS was readministered at the end of this session to record progress. Table 2 summarizes session foci and assessments used in each session.

Table 2

Session Foci and Measures

Week	Focus	Measure
Week 1	Goal Setting	RDAS KMS Goal Sheet
Week 2	Solution Patterns	KMS Goal Sheet
Week 3	Amplifying Exceptions	KMS Goal Sheet
Week 4	Keeping On Track	KMS Goal Sheet RDAS

Analysis of Data

Visual inspection is a common method of analysis in single-case design (Kazdin, 1982) and was used in the present study to evaluate the degree to which a functional relationship between the intervention and behavior change can be inferred. Replication of effects across subjects and at different points in time was considered evidence of a relationship between treatment and positive outcome.

Kazdin (1982) explained that the underlying rationale for analysis by visual inspection in this type of study is that the research should attain effects that are obvious from merely examining the data without further statistical analysis. Interventions may be statistically significant even when they are relatively weak. Thus, the insensitivity of visual inspection for detecting weak effects can be viewed as an advantage rather than a disadvantage in that it "encourages investigators to look for potent interventions or to develop weak interventions to the point that large effects are produced" (p.232).

Statistical analysis was not used in the evaluation of the results of the present study. Although Kazdin (1982) reported that the use of statistical analysis for single-case designs continues to be the exception rather than the rule, he gave examples of various statistical tests that are sometimes used with single-case data.

These tests include t and F tests, time-series analysis, randomization tests, and split-middle techniques.

Time-series analysis and split-middle techniques were not appropriate for the present study because of the limited number of data points. The serial dependency of the data excluded conventional t and F tests. The nature of the study ruled out randomization tests.

A further problem with the requirements of statistical analyses is that obtaining a sufficient number of data points tends to alter the nature of solution-focused therapy itself. Franklin and her colleagues (Franklin, Corcoran, Nowicki, & Streeter, 1995) stated that "changing the therapy to collect outcome data may also change the way clients' problems were constructed, and may even require the defining of problems in ways that are meaningless to the client or even contraindicated to the solution approach" (p. 249).

In the present research, more data points would have made statistical analysis possible, but may have structured the therapy in such a way that it was no longer solution-focused. The emphasis might have changed from a future to a present focus when participants were asked to spend time analyzing the current state of their marriage rather than collaborating on solutions. Also, the time spent taking baseline measurements would tend to dilute

the impact of pretreatment change. To minimize these contraindications to a solution-focused orientation, assessments were kept to a minimum.

CHAPTER 4

RESULTS

Visual examination of outcome data from the solution-focused couples' program indicated a positive trend toward goal achievement and increased marital satisfaction. With the exception of one subject, all participants either maintained or increased their scores on the assessment measures. The replication of a positive trend across the majority of subjects on all measures provided an indication that the experimental criterion had been met.

In some cases, the data showed an initial trend during baseline, but according to Kazdin (1982), "a multiple-baseline design is usually not impeded by initial trends in baseline. It is unlikely that all baselines (behaviors, persons, or behaviors in different situations) will show trend in a therapeutic direction" (p. 264). Conclusions about intervention effects were reached on the basis of the pattern across all subjects.

Research Question 1

Do couples who attend a short-term solution-focused couples' therapy group report increased marital satisfaction? The RDAS (Busby et al., 1995) was designed to measure overall marital satisfaction. Using this measure and comparing baseline and postintervention

scores, 7 participants showed improvement, 2 showed no change, and 1 recorded a decline in his score. Figures 4 and 5 show scores on the RDAS for both groups. Note that the male member of couple 2 in group 1 missed orientation and his scores for the measures given at that time are missing.

The KMS (Schumm et al., 1990) also measures marital satisfaction. The KMS was administered nine times, whereas the RDAS was administered four times. There was greater variability between individual scores for each participant on the KMS, but participants exhibited patterns similar to those of their respective RDAS scores. The overall trend for 7 of the 10 group members was positive. These were the same 7 participants who recorded improvement in RDAS scores. Of the remaining participants, 2 again showed little change in their scores and 1 showed a decline in his score. Figures 6 and 7 show these scores.

Although no statistical comparisons were made, a visual comparison of means suggested improvement in scores on both measures. The baseline mean of the RDAS (Busby et al., 1995) was 44.6 and the mean score after treatment was 48.2, indicating a modest gain of 3.6 points. The standard deviation of pretest scores was 5.1 and the

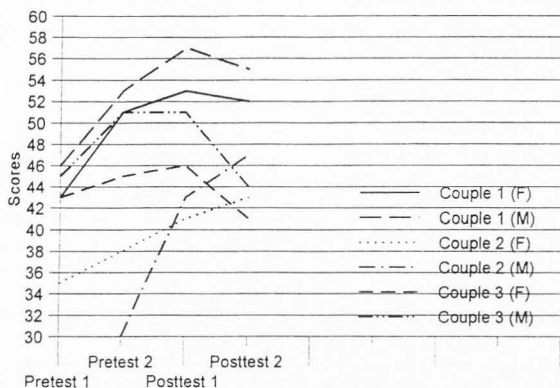


Figure 4. Group 1 participants' scores on the Revised Dyadic Adjustment Scale.

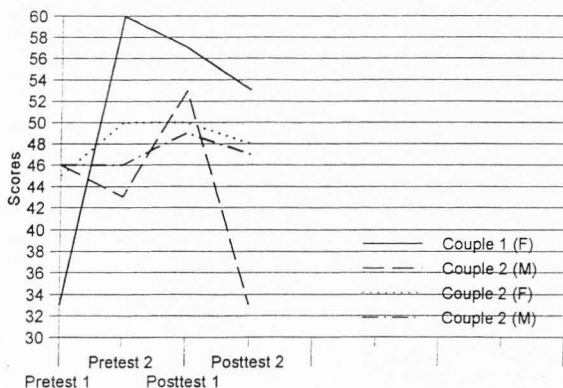


Figure 5. Group 2 participants' scores on the Revised Dyadic Adjustment Scale.

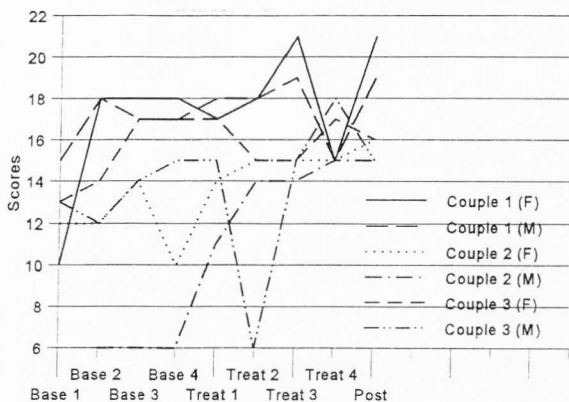


Figure 6. Group 1 participants' scores on the Kansas Marital Satisfaction Scale.

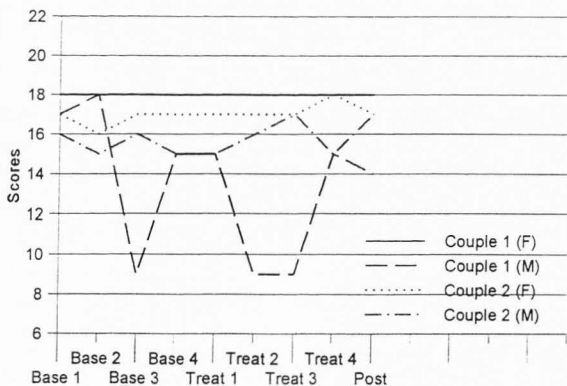


Figure 7. Group 2 participants' scores on the Kansas Marital Satisfaction Scale.

standard deviation of posttest scores was 4.9. Possible scores on the RDAS range from 0 to 69.

An average increase of .9 was recorded on the KMS (Schumm et al., 1990). Baseline mean was 14.9 and the mean of scores recorded during and after treatment was 15.8. Scores on the KMS may range from 3 to 21. Figure 8 shows a comparison of means for all measures.

Research Question 2

Do couples who attend a short-term solution-focused couples' therapy group report progress toward their individual and couple goals? A self-report goal sheet was used to record progress toward individual and couple goals set by group members. The goal sheet consisted of weekly charting on a 0-10 scale with 0 representing no progress and 10 representing complete goal achievement. Seven group members reported progress toward their couple goals. Two members maintained a consistent level of goal achievement and one member reported a decline in progress toward the couple goal.

With regard to individual goals, 8 of the 10 group members reported progress toward their goals. One group member maintained her level of goal achievement and her partner declined in progress toward his individual goal.

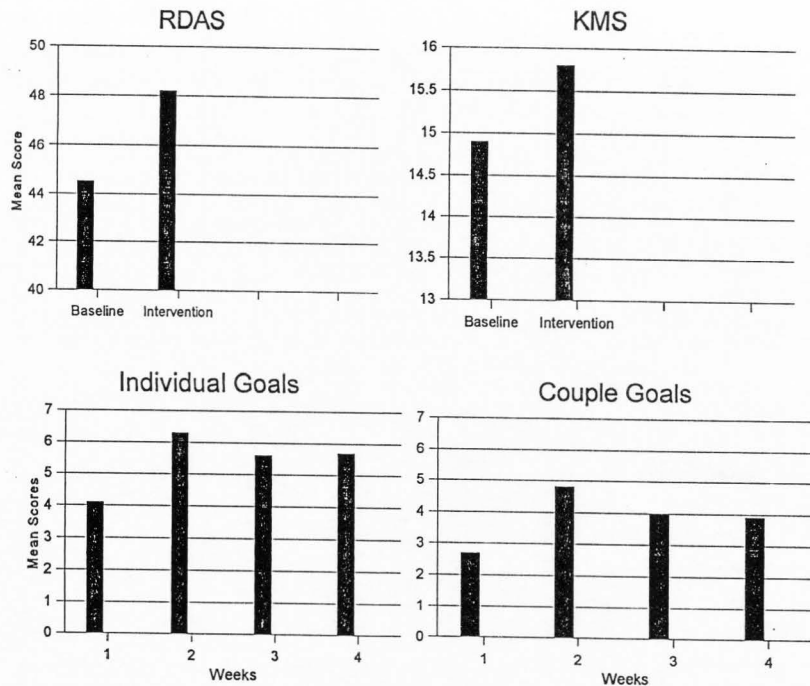


Figure 8. Comparison of means on all measures.

Figures 9-12 are representations of participants' scoring of their progress toward individual and couple goals.

Scores on both couple and individual goals for all participants show an initial increase of approximately 2 points which drops by approximately .7 point in the next 2 weeks. In comparing the mean scores for week 1 and week 4, scores for individual goal progress showed an overall gain of 1.6 points from a mean score of 4.1 at week 1 to a mean at week 4 of 5.7. Scores of couple goal progress increased 1.2 points from a mean of 2.7 to 3.9 (see Figure 8).

Research Question 3

Do partners experience similar results in marital satisfaction and goal attainment?

Scores on the RDAS (Busby et al., 1995) indicate that all but one couple reported baseline and intervention scores within 5 points of one another and with the same general trend. The remaining couple's scores were rather erratic with a 10-point spread on all but one occasion. The female began with the lower score of the two, but ended with the higher score (see Figure 5).

Scores on the KMS (Schumm et al., 1990) indicate a similar starting point and trend for three of the couples

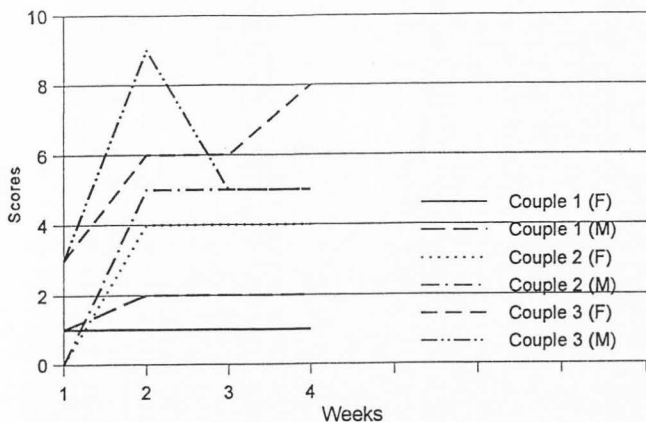


Figure 9. Group 1 participants' scoring of progress toward individual goals.

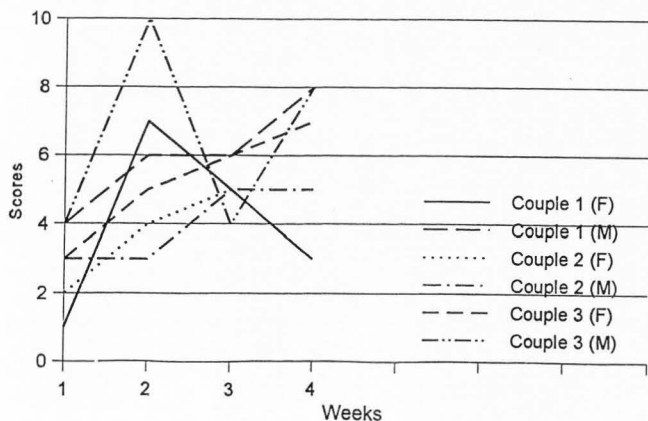


Figure 10. Group 1 participants' scoring of progress toward couple goals.

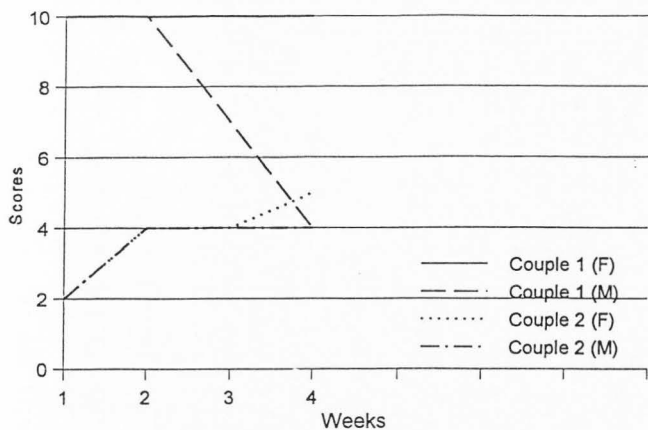


Figure 11. Group 2 participants' scoring of progress toward individual goals.

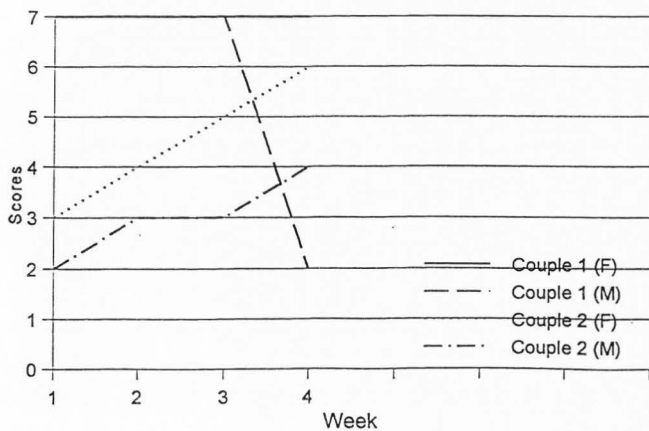


Figure 12. Group 2 participants' scoring of progress toward couple goals.

with the exception of a dip in the male's score for one couple when his wife was out of town. Of the remaining two couples, one couple had a 6-point spread in baseline scores, but both partners reported a similar positive trend and posttreatment scores within 1 point of each other. The remaining couple again was an exception with a large discrepancy in scores (see Figure 7).

A difference score for each couple was computed. These differences were then averaged across couples for the entire sample. The mean difference for the RDAS (Busby et al., 1995) was 4.8 points on the first pre-test and 3.2 on the last posttest. Most couples' scores were very similar (e.g., 2 points); however, the scores of the previously mentioned couple differed by as much as 20 points, affecting the average difference. The mean difference excluding this couple's score was 2.8 on both tests.

The same procedure was used to calculate the average difference on the KMS (Schumm et al., 1990). Mean differences between partners were 1.8 at the first pretreatment assessment, 2.4 at the last pretreatment assessment, 2.2 at the first treatment assessment, 1.4 at the last treatment assessment, and 1.6 at the follow-up. There were no exceptions to the general pattern on this measure. That is, couples reported similar levels of

marital satisfaction.

As would be expected, progress toward couple goal accomplishment was generally similar (e.g., 2 points) for both members of a couple. Individual goal accomplishment was more varied, fluctuating by as much as 5 points. This was true even for the couple whose scores had not followed the general group pattern on the RDAS (Busby et al., 1995).

Mean differences for individual goals were 1 point on the first week and 3 points on the last week. Couple goal progress was characterized by a mean difference of .2 on the first week and 2.4 on the last week.

Field Note Observations

The following analysis of group process is based on field note observations. Although subjective, it lends support to some of the assumptions regarding group and solution-focused therapy that have been reported in the review of literature.

Group Dynamics

The review of literature on couples' group therapy combined with information on solution-focused therapy had suggested that imparting information, directive leadership, imitative behavior, and group cohesion would be important components of solution-focused couples

therapy. This proved to be the case in this sample.

Researcher notes taken during the research process indicate that imparting information was an integral part of the intervention as couples completed homework and reported to the group how they were utilizing new skills. Reporting on homework seemed to be an effective part of group process even when the homework had not been done because it encouraged the person reporting to verbalize what he or she could have done and thus stimulated solution-oriented thinking.

Imitative behavior was evidenced by one couple who reported that they had tried a solution reported by another couple the previous week. Couples also reported past solutions that had worked for them and suggested these to couples experiencing similar problems. It seemed that in each group there was usually one couple who implemented solution-focused language more easily than the others. Other group members then imitated this behavior and all became more skilled at it. One couple in particular picked up on the EARS method of responding and used it to question and reinforce other couples.

Group cohesiveness was evidenced even in this short time-frame. Couples asked one another about goals and made suggestions for goal achievement. At the end of the program, written comments were solicited from the

participants. Group members commented that they enjoyed the friendships that they had made. One group member stated that "we found out that we're not alone"; others also have issues to work on in their marriages.

Directive leadership seemed to be an important factor in keeping group participants on track and maintaining a solution-focused orientation. Discussion sometimes wandered and required redirection to a solution-focused perspective.

Solution-Focused Factors

As is reported in the literature on solution-focused therapy (e.g., Metcalf et al., 1996), clients generally experienced pretreatment change in a positive direction. Focusing on exceptions was a new way of looking at things and seemed difficult for many participants at first, but comments upon completion of the four sessions suggested that they saw this as a more constructive way to view their marriages.

Comments emphasized the effectiveness of the solution-focused perspective: "I agree with others that dissecting the cause of problems is threatening and frequently unsuccessful. This has been our experience." "This class has pointed me in a new direction. It has helped remind me how important it is to look for the good."

One couple reported that they had been doubtful about attending the group because they had tried marriage counseling before and felt that it dwelt too much on the negative. "It felt like all my faults were listed in front of me. We identified all the causes, but not what to do about them." They commented that the couples' group had helped them make positive changes and they liked the fact that they were working toward a common goal. They reported that they had considered divorcing, but now felt that they had tools to improve their marriage. They asked if other professionals use this approach.

Another participant commented that she felt happier now and that she was surprised that even though the changes were small, they had a positive effect. This is in keeping with the solution-focused tenet that small changes can have a "ripple effect" and improve overall satisfaction. A basic premise of the solution-focused model is that couples can get back on track with the aid of therapy and keep the ball rolling from there. Several participants stated that they wished we were doing another group so that they could choose a new goal and work on it with the group.

There were no negative comments from participants in either the written or verbal feedback. Social desirability may account for this lack of criticism, as

may the fact that couples had been coached for 4 weeks on the beneficial effects of concentrating on positives.

CHAPTER 5

DISCUSSION

Solution-focused couples' group therapy was tested using a sample recruited by advertising a relationship enhancement couples' group in the general community in Logan and among clientele at Weber Human Services in Ogden. Assessments were given to measure marital satisfaction prior to, during, and after intervention. Progress toward individually-set goals was measured using a self-report goal sheet during the 4 weeks of group work.

The research utilized a single-case, multiple-baseline design ($n = 10$). Due to the small number of participants, results are not generalizable. Differences may or may not hold in replication of research. Thus, all hypotheses are tentative. Further study is needed to determine whether similar results would be obtained with different populations, sample sizes, and in different settings.

Group size was not optimal according to Reichline and Targow (1990), who cited four couples as the preferred number. However with the present model, a group of three couples seemed to be most workable. Individuals were asked to discuss the same question in turn and when this was done with four couples, it seemed too repetitive. With two couples, the discussion seemed too brief. With

the present sample, it is not possible to determine how size affects outcome; however, this factor should be taken into consideration when interpreting results.

Summary of Findings

Seven out of 10 participants recorded scores on the assessment measures showing improvement in marital satisfaction and specific goal attainment. Two participants maintained consistent scores throughout the assessment period and 1 group member evidenced a decline in scores. These results closely replicate those reported by other researchers (De Jong & Hopwood, 1996) in which roughly 75% of the participants made progress toward their goals. The convergence of scores on both measures of marital satisfaction and on the self-report goal sheet supports the notion that solution-focused couples' therapy can help couples make positive changes in their marriages.

Those with lower initial scores seemed to report the most progress, especially in marital satisfaction as measured by the RDAS (Busby et al., 1995) and KMS (Schumm et al., 1990). Progress on individual and couple goals appeared to be more affected by individual differences, with some participants showing marked progress toward their goals while others showed sporadic gains.

Those participants who did not experience positive

gains on the assessment measures were generally favorable in their comments about the group. This could be attributed to social desirability in wanting to say what the investigator wanted to hear, but it is interesting that their observed affect over the course of the program became more positive and they seemed to converse more cheerfully. However, this might be a result of the investigator seeing what she wanted to see.

Research Question 1

Does attending a short-term solution-focused couples' therapy group increase marital satisfaction? Marital satisfaction was measured using the Revised Dyadic Adjustment Scale (Busby et al., 1995) and the Kansas Marital Satisfaction Scale (Schumm et al., 1990). The RDAS was administered twice as a pretest and twice as a posttest. The KMS was administered continuously: four assessment occasions were pretreatment, four were during treatment, and one was at follow-up. Trends in scores on both measures were similar for all participants, indicating that test sensitization was probably not a factor in outcome results (see Figures 4-7).

Seven out of 10 participants showed positive results on both measures. However, in most cases the increase was modest (e.g., 3 points). The amount of change in marital

satisfaction scores was less pronounced than the change in goal achievement scores. One possible explanation for this phenomenon is that there is a certain amount of lag time before goal achievement translates into marital satisfaction. If this goal achievement continues and if a solution-focused perspective generalizes into other aspects of the relationship, marital satisfaction scores would be expected to show a more pronounced increase.

Busby and colleagues (1995) reported that the mean score of their nondistressed (nonclinical) sample was 52.3 with a standard deviation of 6.6 and the mean for their distressed (clinical) sample was 41.6 with a standard deviation of 8.2. The literature does not give a cut-off point for nondistressed and distressed couples. However, if we were to consider a point midway between these two means (46.9) as a cut-off point, 6 of the 10 participants involved in the current study progressed from a distressed to a nondistressed score on the RDAS. Five of the 10 participants showed gains of one standard deviation or more from first pretest to final posttest scores.

Most participants recording increases in scores on all measures were in group 1. Several factors might account for this discrepancy in individual results between groups. The participants in group one were recruited from

Utah State University and surrounding areas. They were better educated and of a higher socioeconomic status than the participants in group 2. They may have been better able to understand the concepts presented. It could also be argued that they were more experienced in setting and achieving goals and also that they were more accustomed to the test-taking process. Because they were aware of the need for objective reporting, they may have been less susceptible to social desirability factors.

One member of each couple in group 2 was a client of the researcher. Although identification numbers rather than names were used on assessments, social desirability may account for the consistent and relatively high scores for some of these participants. Because groups were small, participants probably realized that their scores might be identified by the researcher. One of these participants in particular was known to experience test anxiety, which may also have influenced her scores. This participant also might not have understood the goal-setting process. She was advised that if she had rated herself as a 10 at initial goal scaling, then she had already accomplished that goal and might want to choose another one. However, she declined to do so. Again social desirability and recognition might have been factors.

The members of group 1 formed a nonclinical sample, whereas one member of each couple in group 2 was receiving individual therapy. Thus, solution-focused couples' therapy may be more suited to a nonclinical sample and might best be utilized as a relationship enhancement program. However, one couple from the nonclinical sample scored lower on the RDAS (Busby et al., 1995) pretest than did those in the clinical sample. Subsequently, this couple showed gains of approximately 10 points between pre- and posttest scores on this measure. Further testing is needed to determine if these results would be replicated with other samples.

The wide disparity in incomes and its apparent correlation with results raises questions as to how and why income levels might affect outcomes. A possible explanation is the stress that low income places on couples. This factor might influence their marital satisfaction and ability to focus on goal accomplishment. Also, they may simply have less time to devote to couple activities.

It is interesting to note that several participants experienced pretreatment change in a positive direction. This phenomenon is often reported in solution-focused literature (e.g., Beyebach et al., 1996) and was supported by the present study.

Research Question 2

Does group attendance facilitate accomplishment of goals set by participants? Couples were asked to form individual goals that would strengthen their relationship and also to collaborate on a goal they would work toward as a couple. As evidenced by visual inspection of progress graphs, participants generally progressed toward their individual and couple goals (see Figures 9-12).

Initial scores for individual goals were usually higher than those for couple goals. Gains from week 1 to week 4 were usually greater, but progress was reported for both types of goals.

Generally, those in group 2 did not show as much consistent progress toward goals as did those in group 1. Participants in group 2 seemed to have more difficulty grasping the concept of goal setting than did those in group 1. The time constraints of the treatment protocol for research did not allow for adding an extra session to clarify the goal-setting process; this, however, might have improved understanding of goal-setting and perhaps improved outcome scores for this group.

Another possibility for the results in group 2 is that there might have been differences in clarity of presentation of the goal-setting process by the researcher

between the two groups. The same treatment manual and materials were used, however. It is difficult to ascertain whether this or other differences might have been factors. The fact that the two females in group 2 were clients of the researcher may have affected results. Demographic factors mentioned earlier may also have influenced outcome.

Participants reported that a solution-focused orientation was a different way of viewing their marriages. By the end of the 4-week program, group members seemed to be somewhat comfortable with this orientation; however, a program lasting 5 or 6 weeks may have allowed participants to more fully implement what they had learned and perhaps would have produced greater progress toward goals.

Research Question 3

Do partners experience similar results in marital satisfaction and goal attainment? Most couples recorded similar scores on the pre- and posttest scores on the RDAS (Busby et al., 1995) and similar baseline and treatment scores on the KMS (Schumm et al., 1990). One couple, however, had extremely different perceptions of their marital satisfaction as evidenced by scores on the RDAS and KMS, with differences as large as 20 points. It

should be noted that the husband in this couple had difficulty with written tests due to vision and arthritis problems. He experienced difficulty matching question lines with response lines and used a bookmark to help him keep track. Arthritis in his hands made written response difficult. These factors may have influenced his scores.

An examination of the self-report goal sheet revealed that partners' progress tended to be similar. Generally, each partner reported similar gains in relation to couple goals. Progress on individual goals was more varied, although still similar (e.g., 5 points) in magnitude and trend. Partners' progress, although for the most part positive, was more dissimilar on the individual self-report goal sheet than on any of the other measures (see Figures 9-12).

Participants perceptions of their initial level of achievement on their couple goal tended to match. Their estimate of progress was also closely related. Couple collaboration was most likely a factor in this outcome, whereas individual goals might have been pursued more independently resulting in divergent outcomes for partners.

Limitations of the Research

Single-case research is particularly suited to a

clinical setting, but this is also one of its limitations. It is difficult with this type of design to rule out threats to internal validity. Since conditions cannot be as closely controlled as in a laboratory setting, it is difficult to rule out extraneous influences. In the present study, participants were self-selected and so it could be argued that they would be more likely to show progress due to their motivation in attending the group. An attempt to control other threats was made by using continuous assessment and staggering the time that treatment began.

A primary objection posed against single-case research is that the findings may not generalize to participants or situations other than those included in the research. It is possible that this contention would prove valid in the present research. However, Kazdin (1982) noted that the analysis used in between-groups research evaluates "average group performance" (emphasis in original) and "does not shed light on the generality of intervention effects among individuals" (p. 282). The replication of effects across subjects in the solution-focused couples' groups was designed to address this threat to external validity.

According to Kazdin (1982), another limitation of single-case research is that although it is "highly suited

to evaluating particular treatment packages and their effects on performance... (it) usually does not address questions of the characteristics of the client that may interact with treatment effects, ...[and] the investigator has no systematic way of determining whether treatment was more or less effective as a function of the treatment or the particular characteristics of the subjects" (p. 281). Thus, in the present study, it is difficult to speculate whether lack of progress should be attributed to characteristics of the participants or of the treatment administration. Additional study with larger groups is needed to further illuminate the relationship between treatment and behavior change.

Lastly, self-report measures of progress are often suspect since they do not constitute an "objective" measurement. However, this limitation is inherent in the use of a solution-focused model. The objective in a solution-focused group is to change perception as well as behavior. If the participant perceives positive change, then the goal has been met. However, perceptions are less easily measured.

Implications and Recommendations

The results of the present study of solution-focused couples' therapy closely replicate those reported by other

solution-focused researchers (De Jong & Hopwood, 1996) in which roughly 75% of the participants made progress toward their goals. This progress toward goal attainment coupled with the recorded increase in marital satisfaction as measured by the Revised Dyadic Adjustment Scale (Busby et al., 1995) and the Kansas Marital Satisfaction Scale (Schumm et al., 1990) lends support to the supposition of positive outcomes from solution-focused couples' group therapy.

Subjective reports by participants indicate that they found the couples' group helpful and enjoyed this way of working to improve their marriages. Working with couples in a solution-focused group not only appears to be therapeutically advantageous, but also has the potential of better utilizing healthcare resources. Four couples could receive treatment from one therapist with no decrease in effectiveness and with the added benefits of positive peer pressure and collaborative solution development. The possibility of more cost-effective resource management would make this approach an attractive alternative for individual therapists as well as healthcare organizations and suggests that further study would be worthwhile. To the extent that particular health maintenance organizations allow flexibility in treatment planning, the type of intervention could be tailored to

the needs of the couple. This study lends support to the assumption that solution-focused couples' group therapy would be a viable treatment option.

The present research contributes evidence that solution-focused therapy in a couples' group is at least as effective as solution-focused therapy with individual couples. However, the lack of progress reported by some participants suggests that this is not the case for everyone. Educational level might be a factor in rate of progress and perhaps a longer and more individualized course of treatment for those with less educational background would prove helpful. Further research with different populations and comparing group work with individual couple work is needed to delineate those couples for whom a solution-focused group approach is most appropriate.

The forming of couple goals during the first session presupposes a minimum level of cooperative communication and perhaps this type of therapy would not be appropriate for extremely conflictual couples. In the present study, scores on the RDAS (Busby et al., 1995) indicate that agreement between partners concerning level of distress is more closely related to improvement in scores than is beginning level of distress. Further research may indicate that a pretreatment screening process taking into

account these considerations would produce better outcomes and would identify those couples who would be better served by other forms of therapy.

Given the fact that approximately 25% of participants in this sample did not show improvement, therapy with individual couples should continue to be an option offered by health maintenance organizations. However, the results of this study suggest that when group work is selected as part of the treatment plan, therapists might consider solution-focused couples' therapy as a viable alternative to traditional group therapy.

The present research was intended to be exploratory in nature because solution-focused couples' group therapy is a newly developed program. However, the positive trend noted in most participants' scores suggests that further study would be warranted. Replication would lend support to the findings of this study.

Although the nature of solution-focused therapy often makes research design challenging, further studies to determine the feasibility of using solution-focused groups with couples and perhaps families would be useful in expanding our knowledge of this type of therapy.

Possibilities that might be studied in the future using between-groups designs include the differential effects of socioeconomic status, educational level, and

clinical versus nonclinical populations using solution-focused couples' therapy. Research could also compare solution-focused couples' groups to traditional couples' groups.

REFERENCES

- Adams, J. F., Piercy, F. P., & Jurich, J. A. (1991). Effects of solution-focused therapy's "formula first session task" on compliance and outcome in family therapy. Journal of Marital and Family Therapy, 17, 277-290.
- Apgar K., & Coplon, J. F. (1985, March-April). New perspectives on structured life education groups. Social Work, 138-143.
- Berg, I. K. (1994). Family-based services: A solution-focused approach. New York: Norton.
- Berg, I. K., & Miller, S. D. (1992). Working with the problem drinker. New York: Norton.
- Berman-Rossi, T. (1993). The tasks and skills of the social worker across stages of group development. Social Work with Groups, 16(1-2), 69-81.
- Beyebach, M., Morejon, A. R., Palenzuela, D. L., Rodriguez-Arias, J. L. (1996). Research on the process of solution-focused therapy. In S. D. Miller, M. A. Hubble, & B. L. Duncan (Eds.), Handbook of solution-focused brief therapy (pp.299-334). San Francisco: Jossey-Bass.
- Budman, S. H., & Clifford, M. (1979, August). Short-term group therapy for couples in a health maintenance organization. Professional Psychology, 419-429.

- Busby, D. M., Christensen, C., Crane, D. R., & Larson, J. H. (1995). A revision of the Dyadic Adjustment Scale for use with distressed and nondistressed couples: Construct hierarchy and multidimensional scales. Journal of Marital and Family Therapy, 21(3). 289-308.
- Coche, J. (1995). Group therapy with couples. In N. S. Jacobsen & A. S. Gurman (Eds.), Clinical handbook of couple therapy (pp. 197-211). New York: Guilford Press.
- Coche, J., & Coche, E. (1990). Couples group psychotherapy: A clinical practice model. New York: Brunner/Mazel.
- Daste, B. M., & Cox, P. O. (1985). Effects of time limitation in a low self-concept children's group. Social Work with Groups, 8(2), 139-143.
- De Jong, P., & Hopwood, L. E. (1996). Outcome research on treatment conducted at the brief family therapy center, 1992-1993. In S. D. Miller, M. A. Hubble, & B. L. Duncan (Eds.), Handbook of solution-focused brief therapy (pp.272-298). San Francisco: Jossey-Bass.
- de Shazer, S. (1985). Keys to solution in brief therapy. New York: Norton.
- de Shazer, S. (1988). Clues: Investigating solutions in

- brief therapy. New York: Norton.
- de Shazer, S. (1994). Words were originally magic. New York: Norton.
- Dies, R. R. (1985). Leadership in short-term group therapy: Manipulation of facilitation? International Journal of Group Psychotherapy, 35(3), 435-455.
- Ettin, M. F., Heiman, M. L., & Kopel, S. A. (1988). Group building: Developing protocols for psychoeducational groups. Group, 12(4), 205-225.
- Franklin, C., Corcoran, J., Nowicki, J., & Streeter, C. (1995). Using self-anchored scales to measure outcomes in solution-focused therapy. Journal of Systemic Therapies, 16(3), 246-265.
- Furman, B. (1998, January). Reteaming: Solution-focused therapy with groups. Workshop presented in Salt Lake City, UT.
- Furman, B., & Ahola, T. (1992). Solution talk: Hosting therapeutic conversations. New York: Norton.
- Hardenburg, S. (1994). Solution focused group work in a community mental health agency. Case Studies in Brief and Family Therapy, 8(1), 59-71.
- Kazdin, A. E. (1982). Single-case research design: Methods for clinical and applied settings. New York: Oxford University Press.
- Lipchik, E., & Kubicki, A. D. (1996). Solution-focused

- domestic violence views. In S. D. Miller, M. A. Hubble, & B. L. Duncan (Eds.), Handbook of solution-focused brief therapy (pp. 65-98). San Francisco: Jossey-Bass.
- Locke, H. J., & Wallace, K. M. (1959). Short marital-adjustment and prediction tests: Their reliability and validity. Marriage and Family Living, 21, 251-255.
- Mandell, D., & Birenzweig, E. (1990). Stepfamilies: A model for group work with remarried couples and their children. Journal of Divorce and Remarriage, 14(1), 29-41.
- McKeel, A. J. (1996). A clinician's guide to research on solution-focused brief therapy. In S. D. Miller, M. A. Hubble, & B. L. Duncan (Eds.), Handbook of solution-focused brief therapy (pp. 251-268). San Francisco: Jossey-Bass.
- Metcalfe, L., Thomas, F. N., Duncan, B. L., Miller, S. D., & Hubble, M. A. (1996). What works in solution-focused brief therapy. In S. D. Miller, M. A. Hubble, & B. L. Duncan (Eds.), Handbook of solution-focused brief therapy (pp.335-349). San Francisco: Jossey-Bass.
- Metz, M. E., & Weiss, K. E. (1992). A group therapy for the simultaneous treatment of marital and sexual

- dysfunctions: A case illustration. Journal of Sex and Marital Therapy, 18(3), 173-195.
- Nelson-Jones, R. (1992). Group leadership: A training approach. Pacific Grove, CA: Brooks/Cole.
- Nichols, M. P., & Schwartz, R. C. (1995). Family therapy concepts and methods (3rd ed.). Boston: Allyn & Bacon.
- O'Hanlon, B., & Hudson, P. (1995). Love is a verb: How to stop analyzing your relationship and start making it great. New York: Norton.
- O'Hanlon, W. H., & Hudson, P. O. (1994). Coauthoring a love story: Solution-oriented marital therapy. In M. F. Hoyt (Ed.), Constructive therapies (pp. 160-188). New York: Guilford Press.
- Rawlings, E. I., & Gauron, E. F. (1973). Responders and non-responders to an accelerated time-limited group. Perspectives in Psychiatric Care, 11(2), 65-69.
- Reichline, P. B., & Targow, J. G. (1990). Couples groups. In I. L. Kutash & A. Wolf (Eds.), The group psychotherapist's handbook: Contemporary theory and technique (pp. 231-252). New York: Columbia University Press.
- Rotholz, T. (1985). The single session group: An innovative approach to the waiting room. Social Work with Groups, 8(2), 143-146.

- Schumm, W. R., Jurich, A. P., & Bollman, S. R. (1990).
Kansas Marital Satisfaction Scale. In J. Touliatos,
B. F. Perlmutter, & M. A. Straus (Eds.) Handbook of
family measurement techniques. Newbury Park, CA:
Sage.
- Shoham, V., Rohrbaugh, M., & Patterson, J. (1995).
Problem-and solution-focused couple therapies: The
MRI and Milwaukee models. In N. S. Jacobsen & A. S.
Gurman (Eds.), Clinical handbook of couple therapy
(pp.142-163). New York: Guilford Press.
- Snyder, M., & Guerney, B. G., Jr. (1993). Brief
couple/family therapy. In R. A. Wells & V. J.
Giannetti (Eds.), Casebook of the brief
psychotherapies (pp. 221-234). New York: Plenum
Press.
- Spanier, G. B. (1976). Measuring dyadic adjustment: New
scales for assessing the quality of marriage and
similar dyads. Journal of Marriage and the Family,
38(1), 15-28.
- Sundel, M., & Lawrence, H. (1977). A systematic approach
to treatment planning in time-limited behavioral
groups. Journal of Behavioral Therapy and
Experimental Psychiatry, 8, 395-399.
- Walter J. L., & Peller, J. E. (1992). Becoming solution-
focused in brief therapy. New York: Brunner/Mazel

- Weiner-Davis, M. (1992). Divorce busting. New York: Summit Books.
- Yalom, I. D. (1975). The theory and practice of group psychotherapy. New York: Basic Books.
- Yalom, I. D. (1995). The theory and practice of group psychotherapy (4th ed.). New York: Basic Books.
- Yalom, V. J., & Yalom, I. (1990). Brief interactive group psychotherapy. Psychiatric Annals, 20(7), 362-367.

APPENDICES

Appendix A.
Treatment Manual
Solution-Focused Couples' Group Therapy

Introduction

Solution-focused Couples' Group Therapy is designed to be a four-session relationship enhancement program. Since the mean number of sessions in solution-focused therapy is four, it is expected that the program will show benefits in this amount of time. The group introduces a solution-focused orientation to dealing with couple relationship problems. "Couple" is defined as any two people, married or unmarried, same or opposite sex, who define themselves as a couple.

Solution-focused therapy concentrates on strengths and resources that the couple already uses. It aims to use these resources to improve the quality of the relationship. Focusing on problems is often counterproductive and self-perpetuating. By focusing on what is going right, problems can often be eliminated. During the course of the therapy program, solution patterns are identified and amplified, while problem patterns are recognized and interrupted. Partners form individual and couple relationship goals and support each other and other group members in the accomplishment of these goals.

The group uses a mixed education and discussion format that has been used successfully in group programs for step-families (Mandell & Birenzweig, 1990), structured life education (Apgar & Coplon, 1985), and couples' groups (Coche, 1995).

Program Structure:

1. Short-term couples group program (4 sessions over a 4 week period. Each session lasts 90 minutes.)
2. Each session involves an assessment of current functioning, a report of homework from the previous session (in the first session, a welcome and orientation take the place of this segment), a "lecturette" on the focus of that session (Coche, 1995), an in-session task and discussion, and assignment of a homework task.
3. A solution-focused orientation is combined with an emphasis on movement towards established relationship goals for each individual.

Session 1

Objective: The purpose of this session is to familiarize couples with each other and with the concept of setting well-defined behavioral goals and using a scaling chart to monitor progress.

Session Outline

Focus: Setting "well-formed" goals	
Welcome, outline of session	5 min.
Introductions, what brought you here	10 min.
Introduction of group policies, signing consent	10 min.
Assessment: RDAS	10 min.
Lecturette on well-formed goals	15 min.
In-session task: Setting individual and couple goals	15 min.
Discuss goals as a group	20 min.
Homework: Formula First Session Task	5 min.

Welcome, outline of session

Sample opening statement:

I'd like to start the session now. My name is LaFray Kelley and I will be your group leader. We plan to meet each Wednesday from 6:00 to 7:30 p.m. for the next 4 weeks. The group's purpose is to help you learn to identify solution patterns and problem patterns in your relationship. Our goals will be to increase solution patterns; to do more of what is working, and to disrupt problem patterns. My role will be to introduce ideas on how to do this and also to be someone who enables you to learn from each other. In this group, you help yourself and each other by participating actively and working hard to reach your goals and help others do the same. The remainder of the session will be spent as follows: first, introduce ourselves and what brings us here; second, learning about setting well-formed goals; third, setting goals and discussing them as a couple and with the group; and fourth, assigning a self-monitoring homework task.

Informed Consent and Assessments

(See Appendices B and C)

Lesson Plan for Lecturette

The Cat only grinned when it saw Alice. It looked good natured, she thought. Still it had very good claws and a great many teeth, so she felt it ought to be treated with respect. "Cheshire Puss," she began, rather timidly.

"Would you tell me, please, which way I ought to go from here?"

"That depends a good deal," said the Cat, "on where you want to get to." Alice-in-Wonderland, Lewis Carroll

- I. Present overview of solution-focused model
 - A. "I'm going to challenge your way of thinking about problems"
 - 1. Our minds can't think in the negative
 - 2. Ask "how," not "why"
 - B. Motivation model= Attractiveness of goal + likelihood of success (Furman, 1998; see materials section for overhead transparencies)
- II. Introduce criteria for well-formed goals (Berg & Miller, 1992; Furman, 1998; Walter & Peller, 1992; Weiner-Davis, 1992)
 - A. Translate generalizations into objective goals, specific actions
 - 1. Politician example: "Truth, Justice, and the American Way", "Make the world safe for democracy" (too general)
 - 2. Describe what you want to accomplish rather than what your partner is doing wrong
 - 3. Action terms, give examples, "movie-making" metaphor, importance of clear "video" of what you would like relationship to be like

Vague

Be respectful

Be more loving

Be more thoughtful

Action

Ask about your day

Compliment your work

Say "I love you" 1 X week

Volunteer to watch kids, so you can go out

Ask what you want to do on weekends

Check with you before making plans

Clean up if you make dinner

- B. Small, realistic, and achievable
 - 1. Introduce scaling and moving one increment at a time.
 - 2. "What would be the first sign that you are accomplishing your goal?"
 - C. In the positive, presence rather than absence of something, what will you be doing instead
 - D. A beginning rather than an end, process form, "ing" words, "on track"
 - E. You must be willing to invest hard work
- III. Demonstrate steps in goal setting

In-session task: Individual and Couple Relationship Goals

- A. Steps in goal setting (Furman, 1998)- Hand out discussion guide (see materials section)
 - 1. Generalizations or attitudes into problems

2. Translate problem behaviors into objective goals
 3. Increase attractiveness of goals by anticipating benefits and describing in concrete terms
- B. Rules for partner discussion:
1. Validate partner's goal
 2. Would it improve our relationship? How?
- C. Discussion points
1. What qualities do you want to develop in yourself that would improve your relationship?
 2. What qualities do you see in your partner that you would like to see more of?
 3. What behaviors can you work on as a couple that will improve your relationship?
 4. What good will come out of reaching your goal? And what good will that do? What else? What will be the benefit for you? For others?
- D. Scale where you are now on 1-10 scale on goal sheet, hand in.

Homework

Formula First Session Task (de Shazer, 1985)

"Between now and next time we meet, we would like you to observe, so that you can describe to us next time, what happens in your ...relationship that you want to continue to have happen" (p. 137).

Session 2

Objective: The purpose of the session is to introduce the concept of solution patterns replacing problem patterns. Couples will elaborate on goal fulfillment through answering the miracle question and finding exceptions; times the miracle is happening now.

Session Outline

Focus: Identifying solution and problem cycles	
Welcome, outline of session	5 min.
Assessment of progress	5 min.
Process homework task	20 min.
Lecturette on problem- and solution-cycles	15 min.
In-session task: Miracle question and discussion	20 min.
Discussion: Signs miracle is beginning to happen	20 min.
Homework: Noticing positive change and problem interruption	5 min.

Lesson Plan for Lecturette

"The first rule of holes: When you are in one, stop digging.

Molly Ivins

Rule #1: If it ain't broke, don't fix it.

Rule #2: Once you know what works, do more of it.

Rule #3: If it doesn't work, don't do it again; do something different.

Insoo Kim Berg

- I. Relationship personality (O'Hanlon & Hudson, 1995)
 - A. Pattern of recurring actions, habits
 - B. Relationship patterns may be easier to change because they develop later in life
 - C. It takes two people acting consistently to make a relationship personality. If either changes, the relationship can (and most likely will) change.
- II. Show solution cycle and problem cycle (Furman, 1998)
 - A. Quicksand analogy- (Weiner-Davis, 1992, p. 100)
The solution is the problem.
 - B. Story- How to be smarter than a rat (O'Hanlon & Hudson, 1995, p. 79) Don't repeat patterns that don't work.
 - C. Baseball Story- Learn from what you're doing right.
- III. Interrupting problem patterns (Weiner-Davis, 1992, p. 145)
 - A. Change anything: What, where, when, who.
 1. What: Notice your "more of the same" behaviors, what would your partner see as different?
 2. Where: Change location of problem pattern

3. When: Change time of problem pattern, time-limited conflict, "timing is everything"
 4. Who: Vary who handles problem
 5. How: change body language and/or tone of voice
- B. Introduce a new step in the sequence
 - C. Predict when the problem will occur
 - D. Do a 180 , handle the problem in the opposite way

In-session task: Miracle Question

(Hand out discussion guide)

Part 1: Suppose that one night, while you are asleep, there is a miracle and the problem that brought you [here] is solved. However, because you are asleep you don't know that the miracle has already happened. When you wake up in the morning what will be different that will tell you that the miracle has taken place? What else? (Berg & Miller, 1992, p. 13)

If the miracle involves others changing, go along with it and then ask, "Then how will you be acting differently?" (Berg, 1994)

Part 2: What signs do you see that you are already on your way?

What will signal other people that the desired change is taking place?

What will be the next sign of continuation of change?

Homework

Notice, so that you can report next week, what was better in your relationship and how you and your partner are progressing toward your goals. If a problem pattern reoccurs, tell us how you interrupted it.

Session 3

Objective: The purpose of this session is to present ways of enhancing positive change by finding and amplifying exceptions, mapping resources, and using solution patterns from other contexts.

Session Outline

Focus: Enhancing positive change	
Welcome, outline of session	5 min.
Assessment of progress	5 min.
Discussion on enhancing positive change (EARS)	10 min.
Process homework task: Notice improvement, thank each other for progress and support.	20 min.
Lecturette on resource mapping and utilizing solutions from other contexts	15 min.
In-session task: Resource mapping with partner	10 min.
Sharing partner's resources with group	10 min.
Homework: Noticing solution patterns from other contexts	5 min.

Discussion on enhancing positive change

- A. Reiterate importance of positive reinforcement from group during homework processing, encourage questioning to amplify exceptions
- B. EARS: (Berg, 1994, see materials section for transparency)
 1. Elicit: What's better? How did you do that?
 2. Amplify: Who else noticed? What did others do differently? How did it affect the rest of your day? What difference did it make in other areas and relationships? (ripple effect)
 3. Reinforce: Posture, tone of voice, attitude
 4. Start over: What else is better?

Lesson Plan for Lecturette

I have been waiting for twenty years for someone to say to me: "You have to fight fire with fire" so that I could reply, "that's funny- I always use water."

Howard Gosage, Zen to Go

- I. Refer to motivation model: Likelihood of success
 - A. Progress already made (homework)
 - B. Assess internal and external resources (Resource map; Furman, 1998; see materials section for example)
 1. Your strengths, what are you good at?
 2. Family members, pets
 3. Friends, colleagues, professionals
 4. People who have died
 5. Heroes, real or fictional

6. Hobbies
 7. Religion, philosophy of life
 8. Movies, books
 9. Imagination
 10. Environment
 11. Anything else
- C. Related areas of competence (O'Hanlon & Hudson, 1995)
1. Solution patterns from the work place
(O'Hanlon & Hudson, 1995, p. 75)
 2. Solution patterns from friendships
 3. Solution patterns from your history together

In-session task: Resource mapping with partner

(Hand out discussion guide)

Each person completes a resource map for his or her partner and shares it with the group.

Homework

1. For the next week, write down things that happened at work or in your friendships that added enjoyment or eased conflicts. Use any of these patterns to improve your relationship.
2. For the next week, notice the things your partner does when you are upset that resolve or soften the conflict.
3. With your partner, discuss things that you two did early in your relationship that increased your feelings of love or resolved conflict.

Session 4

Objective: The purpose of this session is to review concepts from previous sessions, summarize and process learning, and discuss ways to keep "on track."

Session Outline

Focus: Keeping "on track"	
Welcome, outline of session	5 min.
Assessment of progress	5 min.
Process homework task	20 min.
Lecturette on how to keep the ball rolling	15 min.
In-session task: Discuss as couples how to keep on track with positive changes	15 min.
Share credit with partner in the group	15 min.
Assessment: RDAS	10 min.
Closing	5 min.

Lesson Plan for Lecturette

Both the hummingbird and the vulture fly over our nation's deserts.

All vultures see is rotting meat, because that is what they look for. They thrive on that diet.

But hummingbirds ignore the smelly flesh of dead animals. Instead, they look for the colorful blossoms of desert plants.

The vultures live on what was. They live on the past. They fill themselves with what is dead and gone.

But hummingbirds live on what is. They seek new life. They fill themselves with freshness and life.

Each bird finds what it is looking for. We all do.
Steve Goodier

- I. 7 steps to keep the ball rolling (Weiner-Davis, 1992)
 - A. Identify the changes
 1. What's happening that I want to continue to happen?
 2. How have changes affected the rest of my life?
 3. In what ways do I feel better about myself, my partner, and my marriage?
 - B. To what do you attribute these changes? Share the credit.
 - C. Describe what you need to do to keep these changes going.
 - D. Ascertain potential challenges
 - E. Develop a plan to overcome challenges
 - F. Define backsliding
 - G. Develop a plan to reverse backsliding

- II. Stumbling blocks to avoid
- A. Don't expect too much too soon
 - B. Don't expect perfection
 - C. Don't expect failure
 - D. Don't take change for granted

In-session task: Keep the ball rolling

(Hand out discussion guide)

Couples discuss ways to keep the ball rolling with positive changes. They share the credit for success with each other by reporting to the group how they have supported one another in making changes

References

- Apgar, K., & Coplon, J. K. (1985, March-April). New perspectives on structured life education groups. Social Work, 138-143.
- Berg, I. K. (1994). Family-based services: A solution-focused approach. New York: W. W. Norton.
- Berg, I. K., & Miller, S. D. (1992). Working with the problem drinker: A solution-focused approach. New York: W. W. Norton.
- Coche, J. (1995). Group therapy with couples. In N. S. Jacobsen and A. S. Gurman (Eds.), Clinical Handbook of Couple Therapy, (pp. 197-211). New York: The Guilford Press.
- Coche, J. & Coche, E. (1990). Couples group psychotherapy: A clinical practice model. New York: Brunner/Mazel Publishers.
- de Shazer, S. (1985). Keys to solution in brief therapy. New York: W. W. Norton.
- Furman, B. (Jan, 1998). Workshop on Solution-focused Groups. Salt Lake City, UT.
- Hardenburg, S. (1994). Solution focused group work in a community mental health agency. Case Studies in Brief and Family Therapy, 8(1), 59-71.
- Mandell, D., & Birenzweig, E. (1990). Stepfamilies: A model for group work with remarried couples and their children, The Journal of Divorce and Remarriage 14(1), 29-41.
- O'Hanlon, B., & Hudson, P. (1995). Love is a verb: How to stop analyzing your relationship and start making it great. New York: W. W. Norton.
- Walter, J. L., & Peller, J. E. (1992). Becoming solution-focused in brief therapy. New York: Brunner/Mazel, Publishers.
- Weiner-Davis, M. (1992). Divorce Busting. New York: Summit Books.

Materials for Solution-focused Couples' Group

Group Policies

The following policies are based on those suggested by the American Group Psychotherapy Association (adapted from Coche and Coche, 1989). They provide a foundation for the group to function most effectively. We'd like to thank you in advance for honoring and respecting the points discussed below.

Confidentiality agreement within the group: All information discussed in the group meetings is to remain within the room. Names of other group members are not to be brought home to family or friends, and issues involving the lives of other group members are to be held in the strictest confidence. In order to discuss one's own therapy work, the best method is to relate the situation in regard to yourself, pulling in other members anonymously and as little as possible.

The group therapy contract: Group therapy in a group in which members begin and end together is based on members' trust in one another, that each will honor the full time commitment. A commitment to attend all four sessions will enhance the group's effectiveness.

How to work in a group: Because of the nature of the experience, members will benefit from the group whether they sit back and listen or actively pursue issues of importance. Past experience suggests that the greatest benefit can be obtained by being as honest as possible as quickly as possible, and by speaking up.

Thank you for your cooperation with these policies. We encourage you to discuss any questions or disagreements with the group leader.

I have read and understand the above group policies and agree to abide by them.

Client signature

Client signature

Discussion Guide 1

In-session Task: Individual and Couple Relationship Goals

1. What qualities do you want to develop in yourself that would improve your relationship?
2. What qualities do you see in your partner that you would like to see more of?
3. What behaviors can you work on as a couple that will improve your relationship?
4. What good will come out of reaching your goal? And what good will that do? What else? What will be the benefit for you? For others?

Choose one individual and one couple goal, write them on the goal sheet, then circle where you are in relation to the goal on a scale of 1 to 10. Don't forget to include your ID number.

Steps in goal setting

1. Translate generalizations or attitudes into problems
2. Translate problem behaviors into positive goals
3. Increase attractiveness of goals by anticipating benefits and describing in concrete terms (This will be the basis of our group discussion.)

Rules for partner discussion

1. Discuss qualities you would like to see more, choose individual goal
2. Validate partner's goal
3. Would it improve our relationship? How?
4. Collaborate on couple goal

Criteria for Well-defined Goals

<u>Criteria</u>	<u>Key Words</u>	<u>Questions to Ask Yourself</u>
Specific	"Describe"	"Describe specifically how you will be doing this."
In the positive	"Instead"	"What will you be doing instead?"
Beginning, not end	"How" "ing"	"How will you be doing this?"
In your control	"You"	"What will you be doing when that happens?"

Homework

Between now and next time we meet, we would like you to observe, so that you can describe to us next time, what happens in your relationship that you want to continue to have happen.

Discussion Guide 2

In-session Task

Please share with the group your responses to the following questions.

1. Suppose that one night, while you are asleep, there is a miracle and the problem that brought you here is solved. However, because you are asleep you don't know that the miracle has already happened. When you wake up in the morning what will be different that will tell you that the miracle has taken place?
2. What signs do you see that you are already on your way? What will signal other people that the desired change is taking place? What will be the next sign of continuation of change?

Homework

Notice, so that you can report next week, what was better in your relationship and how you and your partner are progressing toward your goals. If a problem pattern occurs, tell us how you interrupted it.

Interrupting problem patterns

1. Change anything:
 - a. What: Notice your "more of the same" behaviors
 - b. Where: Change location of problem pattern
 - c. When: Change timing of problem pattern or time-limit
 - d. Who: Vary who handles the problem
 - e. How: Change body language and/or tone of voice
2. Introduce a new step in the sequence
3. Predict when problem will occur
4. Do a 180 , handle the problem in the opposite way

Discussion Guide 3

In-session TaskResource mapping

Each partner should interview the other and construct a resource map to give to him or her. Use the following ideas to get started. Be prepared to report on your partner's resource map to the group.

1. Your strengths, what are you good at?
2. Family members, other relatives
3. Pets
4. People who have died
5. Heroes, real or fictional
6. Hobbies
7. Religion, philosophy of life
8. Movies, books
9. Imagination
10. Environment
11. Anything else

Homework

1. For next week, write down things that happened at work or in your friendships that added enjoyment or eased conflicts. Use any of these patterns to improve your relationship.
2. For the next week, notice the things your partner does when you are upset that resolve or soften the conflict.
3. With your partner, discuss things that you two did early in your relationship that increased feelings of love or resolved conflict.

Discussion Guide 4

7 Steps to Keep the Ball Rolling

1. Identify the changes. Ask yourself:
What's happening that I want to continue to happen?
How have changes in your relationship affected the rest of your life?
In what ways have these changes helped you to feel better about yourself, your partner, and your relationship?
2. To what do you attribute these changes?
How did I (we) get that to happen?
What would my partner say are the changes that he (she) would want to continue to happen?
3. Describe what you need to do to keep these changes going. What are one or two things that we can do next week to bring us up from a 6 to a 7?
4. Ascertain potential challenges
Is there anything that might occur in the upcoming weeks that would present a challenge to my doing what's necessary to keep the changes going?
5. Develop a plan to overcome challenges
How will I handle this situation differently this time?
What do I need to do to get the results I want?
6. Define backsliding
If we were to backslide, what would we be doing?
7. Develop a plan to reverse backsliding
If we notice that we're backsliding, what will we do?

Motivation

Enthusiasm

Desire to Change

M =

*Attractiveness
of the
goal*

+

*Likelihood
of
success*

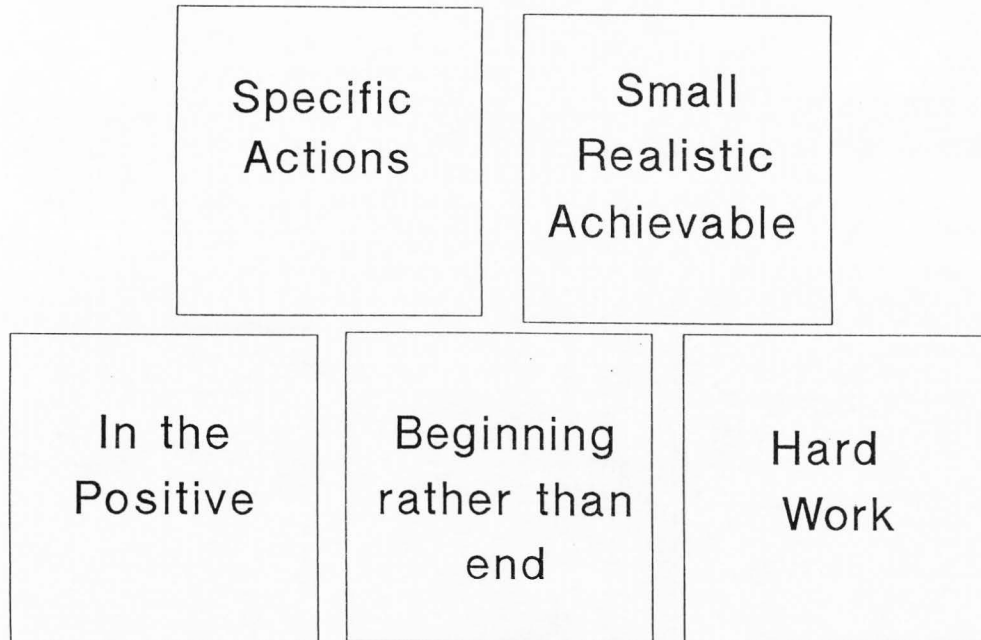


*Benefits to be
expected*



*Available resources
Earlier success
Recent progress*

Building Blocks for Well-formed Goals



Vague

Action

Be respectful

*Ask about your day
Compliment your work*

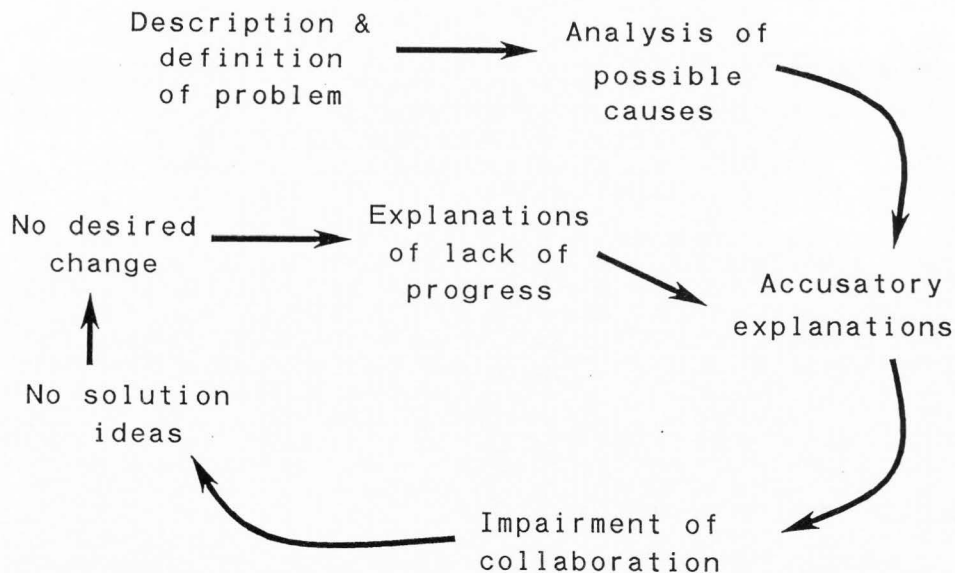
Be more loving

*Say "I love you" 1 X week
Volunteer to watch kids,
so you can go out*

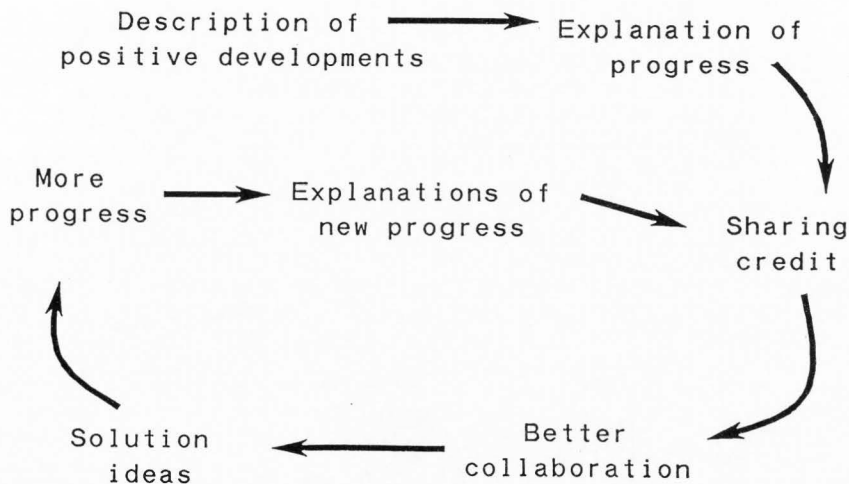
*Be more
thoughtful*

*Ask what you want to do on weekends
Check with you before making plans
Clean up if you make dinner*

Problem Vicious Cycle

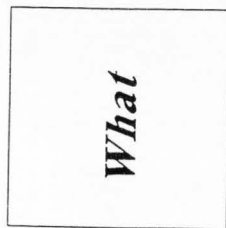


Solution Virtuous Cycle



Interrupting Problem Patterns

Change ANYTHING



EARS

Elicit: What's better? How did you do that?

Amplify: Who else noticed?

What did others do differently?

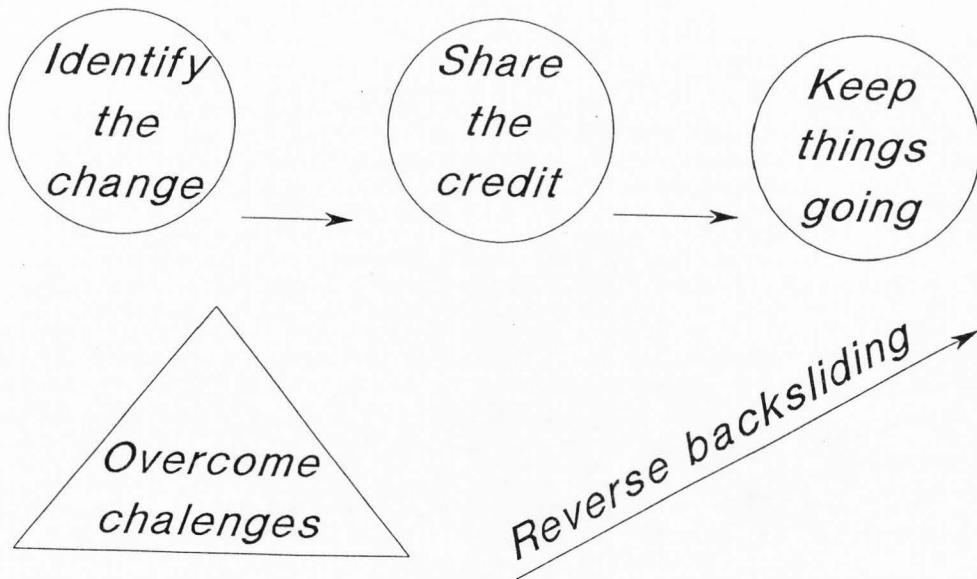
How did it affect the rest of your day?

***What difference did it make in other
areas and relationships?***

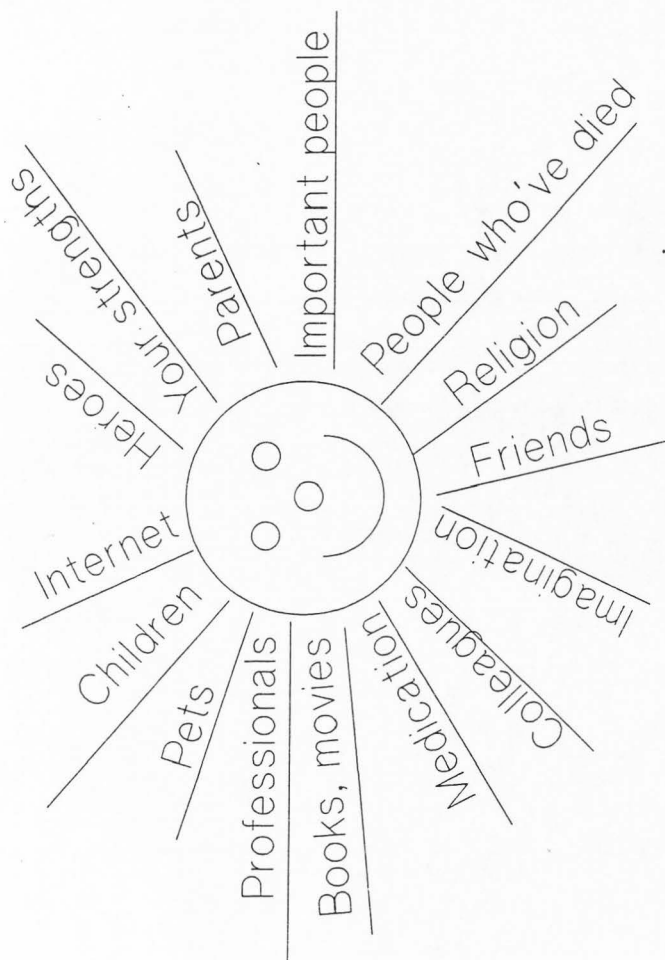
Reinforce: Posture, tone of voice, attitude

Start over: What else is better?

Steps to Keep the Ball Rolling



RESOURCE MAPPING



Appendix B.
Informed Consent Materials

**Utah State
UNIVERSITY**

VICE PRESIDENT FOR RESEARCH OFFICE
Logan UT 84322-1450
Telephone: (435) 797-1180
FAX: (435) 797-1367
INTERNET: lpgentry@champ.usu.edu

May 7, 1998

MEMORANDUM

TO: Thorana Nelson
LaFray Kelley

FROM: True Rubal, Secretary to the IRB *TR*

SUBJECT: Solution-focused Couples Group Therapy

The above referenced proposal was reviewed and approved by the IRB. You may consider this letter to be your approval for your study.

Any deviation from this protocol will need to be resubmitted to the IRB. This includes any changes in the methodology of procedures in this protocol. A study status report (stating the continuation or conclusion of this proposal) will be due in one year from the date of this letter.

Please keep the committee advised of any changes, adverse reactions or the termination of this study. I can be reached at x71180.

*Copy given to
Bradwin School*

Informed Consent
Solution-focused Couples' Group Therapy

It is an ethical principle that the human subjects of a research protocol be informed of the purpose and benefits of the project; the research methods to be used; the potential risks or hazards of participation and the right to ask for further information at any time during the research procedures. Your choice to participate is a voluntary one, and you are free to withdraw from the research project at any time without consequence. Your signature at the end of this consent form will indicate that the principal investigator, or her agent, has answered all your questions and that you voluntarily consent to participate in this investigation.

The purpose of this study is to determine whether short-term solution-focused couples' group therapy has a positive effect on overall relationship satisfaction and specific problem resolution. You are invited to attend Solution-focused Couples' Group Therapy, which is designed to be a four-session relationship enhancement program. Each session lasts 90 minutes and involves an assessment of current functioning, a report of homework from the previous session (a welcome and orientation take the place of this segment in the first session), a "lecturette" on the focus of the session, an in-session task and discussion, and assignment of a homework task. You will also be asked to fill out some questionnaires at the beginning, at the end, and during the course of the group sessions.

Solution-focused therapy concentrates on strengths and resources that a couple already uses. It aims to use these resources to improve the quality of the relationship. During the course of the therapy program, solution patterns are identified and amplified, while problem patterns are recognized and interrupted. Partners form individual and couple relationship goals and support each other and other group members in their accomplishment.

Group therapy may involve discussing relationship, psychological, and/or emotional issues that may at times be distressing. This process is intended to help clients personally and in their relationship. Group members are asked to sign pledges of confidentiality. The therapist will discuss alternative treatments with you if you desire.

Informed Consent
Solution-focused Couples' Group Therapy
Page 2

Information related to you will be treated in strict confidence to the extent provided by law (e.g., where there is reasonable suspicion that the you are likely to harm yourself or others, protective measures will be taken). Your identity will be coded and will not be associated with any published results.

If you have additional questions about this study or your rights, or if any problems arise, you may contact Dr. Thorana S. Nelson at 753-5791. Your participation in this study is voluntary and you may discontinue your participation at any time without consequence and without affecting future services that you would otherwise receive.

I have read and understand this Consent Form and I am willing to participate in this study.

Name of Participant_____

Signature of Participant_____ Date_____

Signature of Principal
Investigator_____

Thorana S. Nelson, Ph.D., Director
Marriage and Family Therapy Program

Appendix C.

Measures

Kansas Marital Satisfaction Scale

Item	Extremely Dissatisfied	Very Dissatisfied	Somewhat Dissatisfied	Mixed	Somewhat Satisfied	Very Satisfied	Extremely Satisfied
1. How satisfied are you with your marriage?	1	2	3	4	5	6	7
2. How satisfied are you with your wife or husband as a spouse?	1	2	3	4	5	6	7
3. How satisfied are you with your relationship with your husband or wife?	1	2	3	4	5	6	7

Progress Report:

ID#: _____

Individual Goal: _____

Couple Goal: _____

Week 1

Individual Goal:	0	1	2	3	4	5	6	7	8	9	10
Couple Goal:	0	1	2	3	4	5	6	7	8	9	10

Week 2

Individual Goal:	0	1	2	3	4	5	6	7	8	9	10
Couple Goal:	0	1	2	3	4	5	6	7	8	9	10

Week 3

Individual Goal:	0	1	2	3	4	5	6	7	8	9	10
Couple Goal:	0	1	2	3	4	5	6	7	8	9	10

Week 4

Individual Goal:	0	1	2	3	4	5	6	7	8	9	10
Couple Goal:	0	1	2	3	4	5	6	7	8	9	10

Appendix D.
Advertisement for Solution-Focused
Couples' Group Therapy

***DO YOU WANT TO IMPROVE
YOUR RELATIONSHIP?***



AND...

HAVE DINNER ON US?

Sign up now for:

**Couples' Relationship
Enhancement Group**

Where: Conference Room

Family Life Center

493 N. 700 E. Logan, UT

When: Wednesdays

6:00-7:30 p.m.

Group is free of charge and runs 4 sessions
beginning May 20. For details call 753-5696.